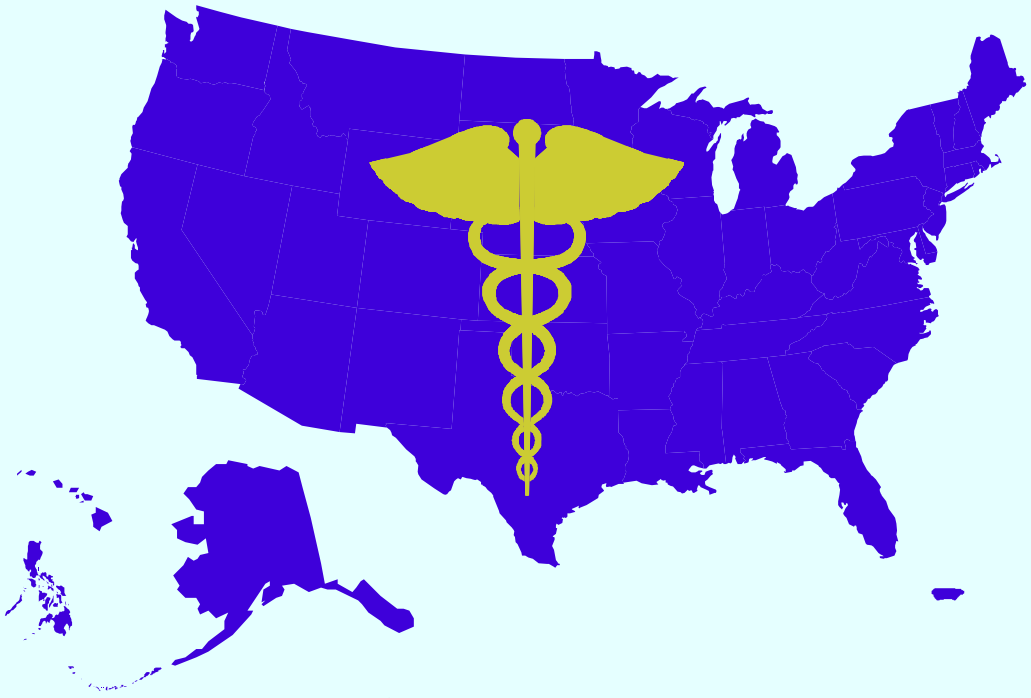
# VETERANS HEALTH ADMINISTRATION

Department of Veterans Affairs

# NETWORK STRATEGIC PLAN SUMMARY 1998 - 2002



"QUALITY HEALTHCARE DELIVERED WITH TRUST, RESPECT, COMMITMENT, COMPASSION AND EXCELLENCE."

*KENNETH W. KIZER, MD, MPH*
*UNDER SECRETARY FOR HEALTH*

NETWORKS 1 THROUGH 22

January 1998

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# PREFACE

The ***Journey of Change***, published in April 1997, was VHA's first strategic plan that described the story of our transformation along the path laid out in ***Vision for Change*** and ***Prescription for Change***. This ***Network Strategic Plan Summary*** builds on the foundation set forth in ***Journey***.

It is difficult to overstate the tremendous – at one time unthinkable – change that has occurred in a very short time. The 1998-2002 strategic plans document the significant accomplishments that have been attained. The plans also show the continued progress we are making in reaching our goal of becoming America's benchmark for healthcare quality.

The achievements outlined in this year's strategic plans are noteworthy and lay the foundation for continued changes throughout the entire system. This document summarizes all 22 plans and shows how our mission, goals, objectives and accomplishments link together over the planning horizon. We will continue to refine our strategic planning process to show more precisely how far we have come and where we are going – providing consistent and predictable high quality healthcare that is delivered with trust, respect, commitment, compassion and excellence.

Kenneth W. Kizer, MD, MPH
Under Secretary for Health

January 1998

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# EXECUTIVE SUMMARY

> ***"While any organization can change or reduce its costs, it is much more difficult to change systematically in a way that produces clear, measurable, improved performance that readily translates into improved service and products at a reduced cost."***
>
> ***Journey of Change, 1997***

Since the publication of ***Journey of Change*** in April 1997, the American health care system has continued along a rapid current of change. At the same time, the veterans healthcare system has achieved significant milestones in responding to these changes, in reorganizing to meet the ongoing challenges, and in becoming more flexible and proactive. This summary of Network plans highlights many of these accomplishments.

Forces driving the changing healthcare market and current trends in the health care environment are highlighted below. They provide a broad context for understanding the veterans healthcare system's strategic direction and the accomplishments of its 22 Networks in attaining the system's strategic goals.

## The Health Care Industry

> ***"There will continue to be marked turmoil among and consolidation of medical groups, hospitals, health maintenance organizations, and other elements of the private sector."***
>
> ***Prescription for Change, 1996***

Between 1980 and 1990, overall healthcare spending by the private and public sectors grew an average of 11 percent a year, climbing from $247 billion to $697 billion. Between 1990 and 1995, health care expenditures grew another 30 percent, reaching almost $988.5 billion. And, in 1996, health care spending topped the $1 trillion mark for the first time, rising to $1.04 trillion. [1]

In 1996, health care spending rose only 4.4%, the lowest rate in 37 years and continuing the downward trend of the two prior years. Nominal expenditures increased 5.1 percent in 1994 and 5.5 percent in 1995. This deceleration in part reflects the impact of managed care and other changes in the health care system. [2]

In 1997, 80 percent of American workers were enrolled in some form of managed care, an increase from 42 percent in 1992 and 5 percent in 1980. [3] More than 14 percent of Medicare beneficiaries are currently enrolled in an HMO or managed care plan. [4] Physicians too are joining the managed care bandwagon in greater numbers. Some 88 percent of all physicians had a managed care contract in 1996, up from 61 percent in 1990.[5]

At the same time, health care in the United States has also made significant progress in the transition from hospital-centered care to ambulatory care. In 1995, the average length of a hospital stay dropped to a historic low of 5.5 days. [6] The rate of hospital admissions had been steadily declining over the decade prior to 1995. The year 1995, however, showed a 0.4 percent increase in the admissions rate due to more hospitalization for seniors.[7]

This transition to ambulatory care is also reflected in a rising number of procedures done on an outpatient basis. Between 1985 and 1995 they grew 89 percent, to approximately 414,000 per year.[8]

The declining rate of admissions and the competitive demands of the new health care marketplace are forcing hospitals to reduce the number of beds and to pursue new organizational arrangements. Between 1984 and 1995, the number of short-stay hospitals dropped by 600 due to closures and mergers, resulting in 260,000 fewer beds nation-wide. [9] Today, hospitals are increasingly consolidating and integrating with other providers in order to create a more comprehensive care system. In 1994, some 22 percent of the nation's hospitals had forged network

links with other hospitals, physicians, home care services, other providers or insurers. One year later 28 percent of hospitals had such arrangements.[10]

The graying of America and growing long-term care costs have become a significant policy issue for the nation's healthcare system. An escalating population of elders—from 35.3 million in 2000, to 40 million in 2010, and 53 million in 2020—will place an ever greater burden on the health care system since they proportionately account for a greater share of health care costs and services than younger cohorts. In 1995 the cost of nursing home care reached almost $80 billion. [11] 90 percent of nursing home residents are elderly. The cost of home health care, amounting to $28.6 billion in 1995, is one of the fastest rising components of health costs. [12]

According to a recent study by the Freedonia Group, health care expenditures are estimated to rise an average of 5.7 percent annually until about 2001. Hospital care costs are expected to grow at the slowest rate – 4.8 percent a year – while long-term care costs are likely to increase the most, growing at a 7 percent annual rate.

## New Federal Requirements

> ***" As a public system, there are increased demands for accountability, more readily demonstrable effectiveness, and greater efficiency."***
>
> ***Journey of Change, 1997***

In conjunction with the rapidly changing healthcare market of the '90s, the federal government has also been revamping, consolidating and reengineering. These changes have been marked by a renewed emphasis on efficiency, quality, cost-effectiveness and customer service. Several studies conducted during this process all reached the same conclusions—in order to meet new federal requirements and guidelines, VA needed to:

- Become more customer-focused
- Reform eligibility rules
- Redistribute resources
- Adopt innovative approaches to improving veterans' access to care
- Increase emphasis on primary care services
- Decentralize organizational decision-making and authority
- Integrate delivery assets to provide a seamless continuum of care

All of these recommendations would also effectively support the VA healthcare system within the turbulent and evolving healthcare market.

## The VA Healthcare Strategy

> ***"Successful organizations have revamped the basic system of hospital-centered care and reformed the patterns of delivery towards managed, patient-centered primary care and necessary specialty care."***
>
> ***Journey of Change, 1997***

VHA responded to the forces driving the healthcare market and reshaping Federal agencies with a transformation strategy outlined in ***Vision for Change*** and ***Prescription for Change***. This strategy is focused on reducing variation in the quality of care, emphasizing outpatient care, enhancing the cost-effectiveness of both clinical and administrative systems, and becoming patient-focused. The four main elements of the strategy are:

- Systematizing quality management
- Increasing access
- Redistributing resources
- Decentralizing management

Specific initiatives supporting this strategy include Patients First—"Putting Veterans First", emphasizing primary care, realigning the organization to support the new healthcare realities, increasing ambulatory care access, decentralizing decision-making, and integrating delivery assets to provide an interdependent, interlocking system of care.

***Journey of Change*** outlined the specific goals and objectives to be achieved within the course set in 1995 for the period of 1997 through 2002. The accomplishments of each VISN, outlined in the summaries, clearly reflect the substantive achievements that VHA has made in meeting the ***Journey of Change*** strategic targets.

## Network Healthcare Delivery

The network plans reflect success in making a number of key changes in the way in which healthcare services are provided to veterans. All networks are incorporating managed care principles and concepts to ensure that high quality patient care is provided in the most appropriate, cost-effective setting. Aspects of managed care that are reflected in the network plans include:

- Assigning patients to primary care teams who are responsible and accountable for providing a large majority of a veteran's healthcare needs
- Expanding the use of clinical practice guidelines
- Implementing case management and utilization management programs to ensure enhanced continuity of care as well as efficient and appropriate service/resource utilization
- Implementing both clinical and administrative service lines based on broad groupings of patients (e.g., Mental Health, Extended Care) and functions (e.g., Business Office, Information Technology)

Coupled with the move to managed care, networks are shifting the focus of healthcare delivery from the inpatient, hospital-based setting to ambulatory settings in an effort to enhance quality and patient satisfaction, reduce cost and increase efficiency. All networks are increasing the number of surgeries and other procedures performed on an ambulatory basis at the same time that they are decreasing the number of operating beds and bed days of care. In doing so, productivity has increased and surgical complications have decreased.

Integration and consolidation of clinical programs, support services, and management within facilities is another strategy that networks are implementing to increase efficiency, improve service satisfaction, and enhance the quality of care provided. Additionally, networks are developing consolidated network-wide contracts for a variety of services and functions including procurement, women's and home health services, and maintenance.

## Access to Quality Healthcare

To ensure that all veterans have access to the services they need, networks are increasing the number of service delivery points by opening new Community Based Outpatient Clinics (CBOCs), particularly in areas that are traditionally under-served. Networks have identified literally hundreds of new locations where these CBOCs might be opened over the next several years.

In addition to establishing new CBOCs, networks are improving access to care through increased collaboration among VHA facilities, as well as with other federal and community-based organizations. Increases in sharing agreements, joint ownership arrangements, and contract services targeted at specific veteran populations (e.g., women veterans, homeless veterans) are also mechanisms being used by the networks to improve access to and quality of care and to reduce cost.

Networks are also examining ways to diversify their revenue sources. Network initiatives designed to increase sources of non-appropriated revenue include consolidating and streamlining medical care cost recovery programs,

taking advantage of enhanced authority to sell products and services and enter into sharing arrangements with a variety of different partners, and marketing services to new and existing customers (e.g., TriCare, CHAMPVA).

## Technology, Education, and Research

All networks are emphasizing the importance of new technology as well as education and research as ways to enhance quality, increase efficiency, and improve service satisfaction. Implementation of telemedicine, videoconferencing, and other telecommunications initiatives throughout the networks will enhance their capability to share information and best practices and will help foster a patient-centered culture. Improved clinical and administrative information systems (e.g., Decision Support System, Computerized Patient Record System) integrated with existing databases will enable networks to more effectively utilize information to achieve their goal of becoming fully integrated, interlocking systems of care.

Increased training and educational opportunities for employees, patients, and clinicians are another integral component of the networks' strategic efforts. These efforts will be enhanced by the use of state-of-the-art technologies (e.g., computer-based training; distance/satellite learning; video teleconferencing) and will reflect changes in healthcare delivery (e.g., realigning residency positions toward primary care).

Research initiatives will be increasingly coordinated across networks and will be demonstrably linked with veterans needs (e.g., geriatrics, mental health, long term care, rehabilitation). Additionally, networks will increase funding for peer reviewed research projects and will align these projects with network strategic targets and operational strategies.

## Customer Service/Satisfaction and Quality

The preeminent characteristic of all network plans is a renewed emphasis on customer service and quality. Network customers encompass not only patients but employees, stakeholders (e.g., Congress, Veterans Service Organizations), and community-based and federal organizations as well.

Examples of strategies employed by networks to increase customer service and satisfaction include increasing customer service training for employees; ensuring a safe, friendly, and comfortable work environment free of discrimination and harassment; enhancing relationships with stakeholders; reducing travel time to access services and service waiting times; providing patients and families with pagers; and, recognizing employees for significant contributions and performance.

Likewise, examples of strategies being employed to increase quality include continuing the implementation of clinical guidelines; implementing case management; initiating disease management as an extension of case management; emphasizing primary and preventive care and shared decision-making; measuring quality on clinical outcomes, functional outcomes, and patient satisfaction; continuing to use patient assessment tools and follow-up via use of End of Life Planning, the Addiction Severity Index, the Chronic Disease Index, and the Prevention Index; developing quality improvement teams where required; and requiring all contracted services to meet established quality standards.

These initiatives combined with renewed attention to patient convenience, privacy and the aesthetic environment in which care is provided and in which individuals work, are all part of network strategies designed to improve customer service and quality and make VA an employer, provider, and educator of choice for all customers.

## The Next Phase

During the next planning cycle, VHA will build upon the successful implementation of the VISN structure, decentralization of VHA operational management, and network successes in further operationalizing the ***Journey***

***of Change*** strategic direction. To support the new paradigm and the networks, VHA has embarked on a course of substantive legislative and administrative restructuring that will include:

- Systematization of Quality Management
- Eligibility reform
- Medicare subvention
- Partnering with federal and community providers
- Opening the system to additional users

These programs should loosen some of the current constraints to VA's ability to compete in the marketplace. At the same time, they represent an additional area of continuous change. Understanding and responding to developments in these areas will represent an additional challenge to the networks' strategic management efforts.

Based on the projected accomplishments presented in the network summaries, we can expect to see a veterans healthcare system that is more proactive, committed to strategic management, and grounded in a planning process targeted to local needs and strategic placement as a community resource. As these characteristics evolve throughout the networks, we will also witness the transformation of the veterans healthcare system into one that can truly serve as a model for other systems, both public and private, in terms of translating improved performance into high quality, cost-effective services and products.

**1** Katherine R. Levit et al., "National Health Expenditures, 1995" *Health Care Financing Review* 18.1 (Fall 1996) pp. 175-214.

**2** Levit, *op. cit.*

**3** KPMG Peat Marwick, Study on Compensation Benefits, June 1997.

**4** Medicare Payment Advisory Commission, *Medicare Risk-Plan Participation and Enrollment: A Chart Book.* October 1997.

**5** American Medical Association, *Socioeconomic Characteristics of Medical Practice, 1997.*

**6** The Prospective Payment Assessment Commission's June 1997 Report to Congress, *Medicare and the American Health Care System,* page 89.

**7** Levit, *op. cit*., page 178.

**8** American Hospital Association, *Hospital Statistics 1995/96*.

**9** Robert Wood Johnson Annual Report, 1996, page 10.

**10** American Hospital Association, *Profile of Hospitals 1997.*

**11** Levit, *op. cit.*

**12** Levit, *op. cit.*

# VA NEW ENGLAND HEALTHCARE SYSTEM (NETWORK 1)
PLAN SUMMARY

## VISN OVERVIEW

The network has been organized into five sub-regions: Far North, Northern, Central, Southern and Western. The estimated FY 1997 veteran population is 1,352,100. Elder veterans, those 65 years old and over, are becoming a substantial segment of the total veteran population. Today, they comprise 37.2 percent of the network's veteran population. By 2000, their size will increase to about 40 percent, and in 2005 to 42 percent. Consequently, development of a comprehensive long term care plan is a priority for FY 1998.

## PLAN HIGHLIGHTS

| | |
|---|---|
| ***Quality*** | • Further develop monitors for clinical practice guidelines implemented in 1997<br>• Implement the five new national clinical practice guidelines<br>• Credential providers and track quality of care in alternative care settings<br>• Institute systemwide utilization program to ensure appropriateness of care using standardized policies and procedures<br>• Establish clinical competencies for providers who serve homeless veterans<br>• Enhance awareness of, access to, and utilization of existing VA and community resources<br>• Establish a seamless continuum of care for patients transitioning from VA to community providers<br>• Implement Case Management as the choice of treatment management<br>• Establish clinical criteria and decision-support rules for determining appropriateness of psychiatric, medical and other clinical care<br>• All contracted services will be required to meet the established quality standards<br>• Consolidate bed capacity and purchase community-based services where it is cost-effective and promotes both access and quality<br>• Quality will be measured on clinical outcome, functional outcomes, and patient satisfaction. When outcome measures are not available, process measures will be used. All providers of services to veterans within VA NEHS will be required to meet defined standards of quality<br>• Develop quality improvement teams if required<br>• Include medical schools in VA planning process to take advantage of inpatient and outpatient innovations in quality of care |

| | |
|---|---|
| ***Performance Measurement System*** | • Remove all bottlenecks to Primary Care Team enrollment<br>• Continue to meet or exceed industry-wide performance standards<br>• Through the use of performance-based interviewing techniques, increase training of a larger percentage of our VISN workforce<br>• Measure admission rate/1000 SSN, labs/1000 SSN, imaging/1000 SSN, primary care panel size, BDOC/panel, pharmacy/1000 SSN, pharmacy prescription cost/member/month, and primary care encounters/patient year<br>• The ELC reviews monthly reports from HSR&D and from the Clinical Board concerning progress made and problems encountered |
| ***Customer Service*** | • Utilize focus groups and local surveys for customer perceptions<br>• Coordinate customer services with transportation support system<br>• Renovate West Haven wards for privacy deficiencies, etc. to provide improved environment for patients |
| ***Primary Care/Case Management*** | • Implement mental health case management pilot program at Boston hospitals<br>• Renovate/expand ambulatory care facilities at Bedford, Boston, Brockton, Providence, Togus, and White River Junction to improve access to care |
| ***Special Emphasis Programs and Six Disabling Conditions*** | • Continue SCI Integrated Care at Brockton/West Roxbury<br>• Use case management as the primary treatment modality for homeless veterans<br>• Implement the Homeless Strategic Plan<br>• Provide a comprehensive assessment for 90 percent of all homeless veterans referred to VA system<br>• Conduct a 30 day post-discharge follow-up for the mental health patient |
| ***Community Based Outpatient Clinics (CBOCs)*** | • Lynn, MA; Haverhill, MA; Framingham, MA; South Shore, MA; Plymouth, MA; Waterbury, CT; Bridgeport Community Center, CT; Portsmouth, NH; Berlin/Littleton, NH; Keene, NH; Greenfield, MA; Hyannis, MA; Southern RI; Western ME; Southern ME; Bennington, VT; Newport, VT; Rutland, VT ('98)<br>• Windham/Willimantic, CT; Torrington, CT; Chicopee, MA ('99)<br>• Danbury, CT; Holyoke, MA('00) |
| ***Service Lines*** | • Implement health service line feasibility study: mental health<br>• Continue health service line feasibility study: integrated ambulatory care<br>• Continue health service line feasibility study: long-term care<br>• Continue implementation of spinal cord injury as a health service line |
| ***Improving Clinical and Administrative Information Systems*** | • Upgrade Area Wide Network<br>• Upgrade Local Area Network<br>• Standardize clinical workstations<br>• Develop corporate intranet |
| ***Communication*** | • Study advantage of installing a coordinated dial plan<br>• Expand video conferencing<br>• Implement data mining of DHCP (Data Marts) for ambulatory data and clinical protocols |

| | |
|---|---|
| ***Education*** | • The network will be a leader in providing needed learning experiences that contribute to the overall success in the provision of care to veterans<br>• Mentoring/coaching with leaders serving as guides to others with their individual development<br>• Use computer based training, participant response distance learning, and job rotations to create enhanced access for employee education<br>• Include trainees in VA Quality Improvement and Customer Service training activities<br>• Through the Dean's Committee structure, assure that both VA and the affiliates needs are addressed in the planning process |
| ***Research*** | • Link Education and Research with current and future needs of veterans; 99 percent of research relates to VA patient care<br>• Focus research and training on special needs of the veteran population<br>• Develop guidelines for the appropriate amount of professional time to be devoted to research activities<br>• Expand research opportunities by exploring sources of research funding beyond the traditional VA and NIH sources<br>• Develop an ongoing forum for discussion of the relationship between research and other programs<br>• Appoint Research Advisory Council<br>• Define the current research agenda across the VISN and develop innovative recommendations for high impact interventions<br>• Increase coordination with affiliated medical schools with regard to making the best use of research opportunities at VA Medical Centers<br>• Expand the opportunities for collaboration and cooperation among the investigators in VISN 1<br>• Explicitly involve research in discussions about the recruitment of new clinicians<br>• Inform our constituents about the contribution of research to the clinical and education activities of our healthcare system |
| ***Sharing Agreements*** | • Explore expansion of sharing with Newport Naval Hospital<br>• Explore sharing with Fletcher-Allen Healthcare System |
| ***Contracting Services*** | • Contract with John Dempsey Hospital for Newington patients requiring inpatient medical/surgical care<br>• If a specific department of care (e g., neurology, cardiac surgery) within a VAMC does not meet established standards, the service will be evaluated for contract options<br>• Provide clinic sessions for Orthopedics, Urology, and General Surgery, University of Connecticut<br>• Examine opportunities to outsource in all areas |
| ***Facility and/or Service Consolidations*** | • Enhance Network Consolidated Laboratory<br>• Examine centralization of biomedical engineering<br>• Radiology collaboration<br>• Expand NEHS centralized acquisitions (purchasing and contracting)<br>• Examine consolidation of fiscal operations<br>• Continue the implementation of the advanced food delivery system ("cook-chill")<br>• Continue network laundry consolidation<br>• Continue pharmacy utilization project |


## NETWORK STRATEGIC PLAN SUMMARY

**Mission Goal:** Decrease System Costs per Patient by 30%

| Operating Strategies | Performance Goals |
|---|---|
| **Shift from Inpatient to Outpatient Care** | **'98:** Increase percent of HCFA procedures performed on an ambulatory basis to 75 percent<br>**'98:** Meet or exceed projected regional Medicare average bed days of care/1000 SSN |
| **Use Information Technology to Increase Efficiency** | **'98:** Provide dermatology consults to Togus via high-resolution computer link from Providence<br>**'98-99:** Implement electronic medical record<br>**'98-00:** Implement information technology plan |
| **Consolidate Tertiary Care / Realign Hospital Capacity** | **'98-00:** Examine need for additional NEHS hospital realignment<br>**'98:** Consolidate dental services within northern sub-region<br>**'98:** Consolidate psychiatry services within northern sub-region<br>**'99:** Complete business plan for the Boston hospital realignment<br>**'99-00:** Implement Boston hospital realignment |

**Mission Goal:** Increase Healthcare Users by 20%

| Operating Strategies | Performance Goals |
|---|---|
| **Develop Marketing and Outreach Programs** | **'98-99:** Develop and implement marketing and outreach programs<br>**'98-99:** Establish "roving" screening/health assessment clinics<br>**'98-99:** Increase SCI healthcare users by 4 percent per year |

**Mission Goal:** Increase Revenues From Non-Appropriated Sources to 10%

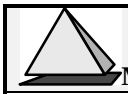
| Operating Strategies | Performance Goals |
|---|---|
| **Contract with Private Sector for Services and Use of Assets** | **'98:** Pilot selling educational services to the community<br>**'98:** Explore the feasibility of filling mail-out prescriptions for DOD<br>**'98:** Implement sharing contract with US Navy for medical and dental services<br>**'98:** Negotiate contract with Sierra Military Services, Inc. to provide CHAMPUS care<br>**'98-00:** Increase SCI non-appropriated sources of revenue by two percent per year |

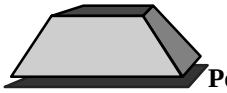
**Mission Goal:** Exceed by 10% Proportion of Patients of Other Providers Who Achieve Maximal Functional Potential

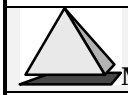
| Operating Strategies | Performance Goals |
|---|---|
| **Monitor Performance at Network and Facility Level** | **'98:** Follow-up ASI patients with a primary diagnosis of substance abuse |

**Mission Goal:** 90% of Patients Rate VA as Very Good or Excellent

| Operating Strategies | Performance Goals |
|---|---|
| **Increase Effective Utilization of Customer Satisfaction Data** | **'98:** Monitor CSS ratings to trend data for high outliers<br>**'98:** Develop quality improvement teams |
| **Expand and/or Implement Integrated Customer Service Training Programs** | **'98:** Expand customer service training at all facilities<br>**'98:** Implement network customer service training<br>**'98:** Implement network customer service recognition program |

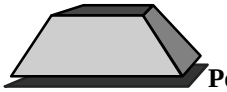

**Mission Goal**: 90% of Patients Rate VA Care Better Than Others

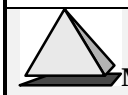
|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Increase Effective Utilization of Customer Satisfaction Data** | **'98:** Remove all bottlenecks to primary care team enrollment<br>**'98:** Monitor and evaluate new access points<br>**'98:** Expand hours and services to meet/exceed expectations of users<br>**'98:** Shift the number of residency slots from specialty to primary care |

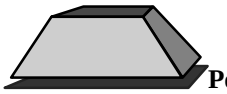

**Mission Goal:** 99% of Research Relates to VA Patient Care

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Enhance Research Activities of the Clinical Staff to the Overall VISN Mission** | **'98:** Establish a research advisory council<br>**'98:** Develop guidelines on the appropriate amount of time to be devoted to research activities |


**Mission Goal**: 95% of Trainees Rate VA Better than Others

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Develop a Rating System to Determine Satisfaction Level of VA Trainees** | **'98:** Establish focus group to determine perceived goals of VA trainees in working with veterans<br>**'98:** Provide education on VA customer service standards<br>**'98:** Include trainees in the VA QI and CS training activities |


**Mission Goal:** Increase Employee Education (Quality Improvement or Customer Service) to 2% of Employee's Paid Time or 40 Hours/Year

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Enhance Employee Education** | **'98:** Standardize employee orientation programs<br>**'98:** Cross-train staff to meet changing needs<br>**'98-00:** Implement network education strategic plan<br>**'98-00:** Develop strategies to achieve proper mix of staff to meet the needs of the network |

## 1997 SELECTED ACCOMPLISHMENTS

- Reduced hospital beds by over 40 percent and implemented lodging beds at each facility
- Completed consolidation study for Boston and West Roxbury
- Adopted 18 clinical practice guidelines
- Conducted study to evaluate utilization of acute medical/surgical beds at Boston and West Roxbury
- Conducted retrospective review of acute psychiatry and substance abuse discharges
- Developed an "Inter facility Patient Urgent Transfer" policy
- Formed network consolidated laboratory
- Expanded centralized acquisitions
- Examined expansion of "cook-chill" program
- Consolidated Nuclear Medicine and Radiology services at Brockton/West Roxbury, Connecticut, and Providence
- Decommissioned CAT scan unit at Manchester
- Implemented a network formulary
- Developed a mental health business plan for each facility
- Developed SCI health service line
- Developed a strategic plan for homeless veterans
- Opened CBOC at Stamford, CT and Pease Air National Guard base
- Expanded after hours clinics
- Conducted a VISN-wide transportation study
- Implemented an information technology plan
- Implemented Microsoft Exchange at all facilities
- Brockton/West Roxbury established a marketing team to expand DOD offerings
- Manchester rented space on their tower to cellular phone companies
- Connecticut expanded DOD sharing agreements to include laboratory and radiology
- Established specialty clinics at Manchester in collaboration with Boston and White River Junction
- Established a Compensatory and Pension Continuous Improvement Team
- Provided Ambulatory Care Leadership Training
- Established a VISN education center at Bedford
- The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) rated VA NEHS hospitals the highest quality ratings in a recently completed review
- Pilot programs in mental health, primary care, and utilization management have been implemented
- The overall satisfaction with outpatient quality of care for VA NEHS (67 percent) exceeds the national VA average of 61 percent
- Continuous Quality Improvement (CQI) team was established at the Boston VAMC to improve the C&P examination process
- Interdisciplinary groups have been formed to work collaboratively on performance improvement
- Patient screening tools are being developed and used by nurses and ancillary staff in outpatient clinics
- Quality Management staff is reviewing performance criteria on an ongoing basis and providing training
- Realigned staffing at several VISN facilities. Reduced staffing throughout the VISN by attrition and hiring freezes
- A network Commodity Standards Committee was established along with the implementation of a network-wide inventory program for the SPD Sections of A&MMS
- Facilities have communicated, by telephone and mass mailings, with those veterans who have used VA before but have not stayed within the system on an ongoing basis. They were invited to return to VA should they need further medical care
- Network VAMCs regularly support their local, state and regional agencies in comprehensive emergency preparedness. Drill scenarios are conducted periodically that involve internal and external events

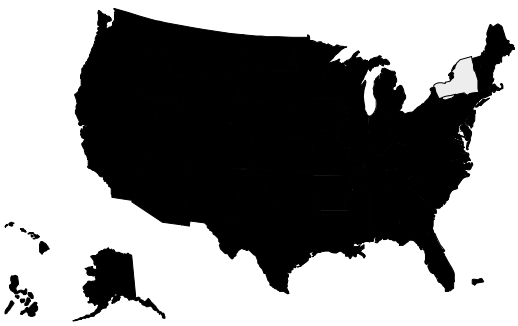
***Information as of December 12, 1997. The financial and workload information presented in this package is currently under review for use in budget justifications submitted to Congress.***

**BUDGETARY DATA SET (VISN 1)** **Table B-1**

| | 1997 Base | 1998 Tactical | 1999 Strategic | 2000 Strategic | 2001 Target | 2002 Target | 2003 |
|---|---|---|---|---|---|---|---|
| **1. Financial ($'s in thousands):** | | | | | | | |
| a. Medical Care, Sources of Funding: | | | | | | | |
| VERA Allocation for Medical Care | $844,887 | $809,476 | $794,171 | $794,171 | $794,171 | $794,171 | |
| MCCR Collection [See Note] | | $28,000 | $35,743 | $39,997 | $44,005 | $48,015 | |
| Medicare Reimbursement | | | | $25,198 | $27,723 | $30,249 | |
| Tricare Collection | | | | | | | |
| Other Sharing/Reimbursements | $9,233 | $8,997 | $9,854 | $10,839 | $11,923 | $13,116 | |
| Planned Unobligated Balances | ($9,271) | $0 | ($2,067) | ($866) | | | |
| **Total = Allocation + Revenues** | $844,849 | $846,473 | $837,701 | $869,339 | $877,822 | $885,551 | $0 |
| b. Percent Revenues to Allocation + Revenues | 1.09% | 4.37% | 5.44% | 8.75% | 9.53% | 10.32% | |
| c. Distribution of Funding by selected activities: | | | | | | | |
| Acute Hospital Care | $387,514 | $384,045 | $381,003 | $394,812 | | | |
| Outpatient Care | $412,711 | $409,016 | $405,776 | $420,483 | | | |
| Long-Term Care | $53,895 | $53,412 | $52,989 | $54,910 | | | |
| Total | $854,120 | $846,473 | $839,768 | $870,205 | | | |
| **2. Federal Employment:** | | | | | | | |
| Average Employment (FTE), Total | 9,961 | 9,352 | 8,794 | 8,547 | | | |
| **3. Unique Patient Users (PRPs): [Unduplicated at the National Level]** | | | | | | | |
| a. Total Unique Patient Users (PRPs) | 148,965 | 154,551 | 160,347 | 166,360 | 172,598 | 179,071 | |
| Percent Increase/Decrease from 1997 Base | | 3.75% | 7.64% | 11.68% | 15.86% | 20.21% | -100.00% |
| b. Distribution of PRPs by Eligibility Category: | | | | | | | |
| Category A | 124,967 | 129,653 | 134,515 | 139,559 | | | |
| Category C | 6,361 | 6,599 | 6,847 | 7,104 | | | |
| Non-Veteran Users | 17,637 | 18,299 | 18,985 | 19,697 | | | |
| Total | 148,965 | 154,551 | 160,347 | 166,360 | | | |
| c. Distribution of PRPs by VERA Patient Groups: | | | | | | | |
| Special Care Unique Patient Users | 7,448 | 7,728 | 8,017 | 8,318 | | | |
| Basic Care Unique Patient Users | 141,517 | 146,823 | 152,330 | 158,042 | | | |
| Total | 148,965 | 154,551 | 160,347 | 166,360 | | | |
| **4. Workload Episodes:** | | | | | | | |
| a. Outpatient Visits (Staff & Fee) | 1,869,000 | 1,963,000 | 1,923,000 | 1,985,000 | | | |
| b. Acute Hospital Care: | | | | | | | |
| Acute Hospital Beds | 967 | 960 | 972 | 972 | | | |
| Acute Hospital ADC | 822 | 816 | 826 | 826 | | | |
| Acute Inpatients Treated | 25,350 | 25,699 | 25,744 | 25,623 | | | |
| c. Long-Term Care: | | | | | | | |
| Long-Term Beds | 2,984 | 3,322 | 3,439 | 3,577 | | | |
| Long-Term ADC | 2,835 | 3,156 | 3,267 | 3,398 | | | |
| Long-Term Inpatients Treated | 3,722 | 4,144 | 4,289 | 4,461 | | | |
| **5. Number of Facilities:** | | | | | | | |
| VA Hospitals | 9 | 9 | 9 | 9 | | | |
| VA Nursing Home Care Units | 7 | 7 | 7 | 7 | | | |
| VA Domiciliaries | 2 | 2 | 2 | 2 | | | |
| Outpatient Clinics: | | | | | | | |
| Hospital Based, Independent & Mobile | 10 | 11 | 11 | 11 | | | |
| CBOCs, CBCs, Satellite & Outreach | 40 | 56 | 57 | 59 | | | |
| **6. Financial Measures (Medical Care):** | | | | | | | |
| a. Obligations Per Unique User Analysis (30% network goal): | | | | | | | |
| Obligations Per Unique User | $5,671 | $5,477 | $5,224 | $5,226 | $5,086 | $4,945 | |
| Percent Change from 1997 Base | | -3.42% | -7.88% | -7.85% | -10.32% | -12.80% | |
| Assumed Portion Current Services | | 3.75% | 7.63% | 11.63% | 15.45% | 19.92% | 24.28% |
| Percent Change Net of Current Services | | -7.17% | -15.51% | -19.48% | -25.77% | -32.72% | |
| b. % Change in Unique Patient Users from 1997 base, from line 2a. above (20% network goal) | | 3.75% | 7.64% | 11.68% | 15.86% | 20.21% | -100.00% |
| c. % Revenues to Allocation + Revenues, from line 1b. above (10% network goal) | 1.09% | 4.37% | 5.44% | 8.75% | 9.53% | 10.32% | |
| d. % of Acute Hosp.$s to Tot.of Acute $s + OP $s | 48.43% | 48.43% | 48.43% | 48.43% | | | |
| e. Outpatient Visits Per Unique User | 12.55 | 12.70 | 11.99 | 11.93 | | | |
| f. Med. Care Capital Obligations Per Unique User | $262 | $265 | $244 | $227 | | | |

# VA HEALTHCARE NETWORK UPSTATE NEW YORK (NETWORK 2)
PLAN SUMMARY

## VISN OVERVIEW



Encompassing 47 New York and two Pennsylvania counties, VA Healthcare Network Upstate New York services an estimated veteran population of over 600,000, serving more than 87,000 unique patients. Over 46 percent of service utilization is by veterans aged 65 and older. As the first VA member of the National Chronic Care Consortium, the network is working to reform the chronic care system by being a part of the "national laboratory" for refining strategies for integrating care financing and information systems.

## PLAN HIGHLIGHTS

| | |
|---|---|
| ***Quality*** | • Continued implementation of clinical practice guidelines across the network<br>• Strengthening of care/case management resources to ensure the best linking, managing, and coordinating of services to meet veteran needs<br>• Initiation of disease management as an extension of case management<br>• Review critical care processes and identify at least two major service deliveries to be reengineered as part of risk management enhancement efforts<br>• Establish and implement a program for hospice and respite care<br>• Maintain Balanced Scorecard as strategically focused tool<br>• Establish standard practice requiring taking of military histories for inclusion in patients' charts<br>• Develop uniform measures for Pharmacy Services across the network<br>• Continue using client assessment tools and follow-up via use of End of Life Planning, Addiction Severity Index, Chronic Disease Index and Prevention Index<br>• Develop single, standard assessment instrument across the network which is based on minimum data set instead of RUGS assessment tool<br>• Implement length of stay guidelines for all care lines<br>• Perform 30-day follow-up after hospitalization for mental illness<br>• Establish/implement network program for end of Life Planning and Advance Directives<br>• Investigate use of alternative medicine and adjunct therapies<br>• Implement comprehensive network pain control, pain management program |

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| ***Performance Measurement System*** | • The network monitors performance by using *Pulse Points*, a tactical tool which contains many of the Network Director's performance measures, as well as other data elements used for monthly management reports<br>• Maintain Balanced Scorecard as strategically focused tool |
| ***Customer Service*** | • Implement Kaset Training, a behavior-based customer service skill development program (a total of 1,000 staff, including supervisors, will receive this nationally recognized training)<br>• Implement a network-wide clinic cancellation policy with a goal of reducing clinic cancellations by 50 percent<br>• Peer/consultation teams will visit each facility to offer new insights for improvements in customer satisfaction<br>• Semi-annual briefing of the medical/dental staff at each medical center highlighting the progress made and areas for improving customer service<br>• Explore implementation of a customer pager program throughout the network<br>• Network 2 has established a strategic goal of 30 minutes travel time to primary care for every enrolled veteran, with 60 percent of veteran users within 30 minutes travel time in '98 |
| ***Primary Care/Case Management*** | • In FY98 initiate disease management as an extension of case management<br>• In FY98 enhance seamless continuum of care - strengthening of case management resources<br>• Beginning in FY98, focus of care from episodes of treatment to continuity of care and maintenance of health; reductions in inpatient care will be balanced by expanded alternatives such as outpatient services<br>• Shift resources from specialty/sub-specialty programs to support the expansion of primary care |
| ***Special Emphasis Programs and Six Disabling Conditions*** | • The network has received a $68,000 grant from New York State to access and educate homeless veterans in central New York<br>• PTSD outreach is targeted to expand in FY98; including conversion of an in-house program at Batavia into a more cost-effective PTSD residential treatment program<br>• Syracuse enhanced its Gulf War veterans' program by establishing a network referral center for the evaluation of spouses and family members, and initiated Saturday clinics to expedite exams and provide convenient access<br>• Establish stronger links with the Paralyzed Veterans of America to investigate the feasibility of strategic initiatives to better serve the needs of veterans with spinal cord injury, multiple sclerosis and other spinal cord diseases<br>• Improve the integration of Compensated Work Therapy (CWT) vocational rehabilitation |

| | |
|---|---|
| ***Community Based Outpatient Clinics (CBOCs)*** | • 1998: Glens Falls, Niagara Falls<br>• Awaiting congressional review: Kingston (with, Albany primary care network, Bennington VT (with Network 1)<br>• No fiscal year for these future sites: Amsterdam/Johnstown, Auburn, Oswego, Sullivan County (joint venture with Network 3); Columbia County, Greene County, Herkimer County |
| ***Community Based Care Initiatives*** | • Expanding the continuum of home based primary care<br>• Telemedix home care pilot for HBPC (blood pressure, grade scale, pulse oximeter, touch screen stethescope transmit unit)<br>• Healthcare information centers which utilize a multimedia approach to providing patient education and participation<br>• Self-care initiatives to be investigated include use of interactive computer programs for healthcare advice on such topics as breast cancer and prostate cancer, access to healthcare queries on the internet in convenient locations at medical centers, and potential use of information kiosks<br>• Establishing targeted information centers in primary care areas, including videos in waiting room as well as patient-specific access in private areas |
| ***Service Lines*** | • While budget dollars have been allocated to the medical centers, "shadow budgets" will be maintained for the care and service lines in anticipation of transfering budget authority to the care lines in '99<br>• The Managed Care Line will continue its focus of reducing bed days of care, increasing turnover, and realigning resources to ambulatory care services including chest pain clinics, increased use of home based primary care, use of non-physician resources and case managers<br>• The Geriatrics and Extended Care Line has aggressive occupancy rate and length of stay targets in order to reduce cost levels to an adjusted national contract standard for nursing homes. There will be a continued focus on providing alternate, non-institutional delivery of care with an increased use of commercial resources and case management<br>• The Mental Health Care Line continues to focus on residential rehabilitation programs, consolidation of domiciliary operations and the realignment of staff to alternate revenue opportunites with New York State Department of Corrections partnerships<br>• The Diagnostics and Therapeutics Care Line will focus on the consolidation of pharmacy and prosthetics services across the Network, decreasing non-formulary purchases and maximizing the cost-effective use of a Consolidated Mail-Out Pharmacy (CMOP)<br>• The service line approach will provide the organization and support to growing care lines. The framework of the new organization will be defined, allowing for alignment and integration of Fiscal, Acquisition and Materiels Management, Human Resource Management, and Information Management functions across the care lines |

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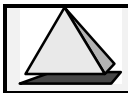
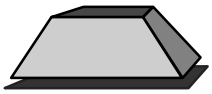
|---|---|
| ***Improving Clinical and Administrative Information Systems*** | • Implement CPRS at the Key Site (Buffalo) with participation from all network VAMCs and begin network-wide implementation of Text Integration Utility, List Manager, Pharmacy Management Module, and the Graphical User Interface<br>• Creating on-line access to clinical practice guidelines<br>• Begin development of on-line prompts and identification of automated data pieces for on-line measurement of clinical practice guideline compliance<br>• Invest in information systems infrastructure in support of mission-critical initiatives including PAY VA, enrollment systems, replacing the current billing system with a commercial solution, provider profiling, DSS, video conferencing, telemedicine, enhanced mail systems, knowledge and decision support databases (web based or networked)<br>• Creation of a certified data analyst program that will define a curriculum for enabling care lines to find and understand data relevant to running their businesses<br>• Enhanced telemedicine and teleradiology at tertiary care sites, CBOCs and in mini lab mobile<br>• Implementation of Lab Expert System (LES), a computer assisted expert system that identifies inappropriately ordered laboratory tests |
| ***Communication*** | • Systematize the process of communicating network mission, vision, and values to all employees<br>• Focus on creation of new communication processes within each of the care lines to ensure a smooth transition to the new organizational structure, to facilitate consistent expectations and address employee concerns<br>• Develop a consistently applied, integrated multimedia advertisement plan to inform and educate internal and external customers and stakeholders in the new and improved VA healthcare system |
| ***Education*** | • An education partnership between the Binghamton CBOC and the State University of New York will create a primary care rotation for residents and medical students<br>• Implement and evaluate education programs that will keep the network competitive<br>• Establish an effective process to ensure that cooperative efforts with the Employee Education System will maximize the benefits and resources expended for network employee initiatives<br>• Add a patient-family education budget service line<br>• Participate in a beta-test of Microsoft Access Data Base Education Tracking<br>• Appoint Process Action Teams and work groups to survey education needs within the network<br>• Continued focus on staff education in the areas of substance abuse, clinical practice guidelines, customer service education, and group therapy |

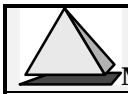
| | |
|---|---|
| ***Research*** | • Increase the number of VA merit review applications and NIH proposals by 5 percent<br>• Foster pharmaceutical industry-sponsored clinical trials through the Research Entrepreneurial Group (REG)<br>• Initiate an HSR&D proposal to assess the ability of the system to provide care to Category C veterans and determine whether the cost of providing that care can be offset through the development of additional revenue streams (MCCF) |
| ***Sharing Agreements*** | • A partnership agreement with the F.F. Thompson Hospital whereby they will provide mammography and clinical autopsies, Canadaigua VAMC will provide therapeutic pool time and chaplain mentoring<br>• Utilize or lease Griffiss Air Force Base Hospital space<br>• The angiography suite at Syracuse is the subject of a sharing agreement with community providers |
| ***Contracting Services*** | • A capitated contract for primary care services in Watertown to replace the VA clinic at Fort Drum |
| ***Managing Human Resources*** | • The network decrease in physician, registered nurse, technician, and nurse assistant staffing is due to the shift from inpatient care to outpatient venues<br>• The increase in physician assistant, nurse practitioners, and licensed practical nurses reflects primary care expansion |
| ***Facility and/or Service Consolidations*** | • Planned service integrations include fiscal, prosthetics, pharmacy, and information resources |
| ***Emergency Preparedness*** | • The Comprehensive Emergency Management (CEM) Program will provide the network with a systematic approach for development, implementation, maintenance and ongoing evaluation |


## NETWORK STRATEGIC PLAN SUMMARY

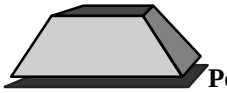


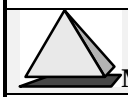
**Mission Goal:** Excellence in Healthcare Value

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Increase Number of Veterans Served** | • 60 percent of veteran users will be within 30 minutes travel time to primary care<br>• Establish veterans health resource centers at Hornell, Wellsville and Penn Yan<br>• Access to medical advice via toll free number, 24 hours a day, seven days a week<br>• Expand use of the mini lab mobile to reach remote/sparsely populated portions of New York State<br>• Establish adult day healthcare access through every medical center<br>• Expand continuum of home based primary care<br>• Tele-medix home care pilot for HBPC (blood pressure, grade scale, pulse oximeter, tough screen stethoscope transmit unit)<br>• Establish an assisted living pilot at Canandaigua<br>• Plan outpatient expansion in Bath, Buffalo and Canandaigua |
| **Lower Unit Cost** | • Decrease bed days of care and lengths of stay<br>• Increase ambulatory surgery rate to 75 percent<br>• Increase the use of non-physician providers (physician assistants, nurse practitioners and pharmacists)<br>• Reduce NHCU cost levels to adjusted national contract standard for nursing homes<br>• Decrease non-formulary purchases<br>• Maximize cost-effective use of CMOP<br>• Implement provider profiling<br>• Twenty-percent reduction of OWCP incidents<br>• Phase II of renovation to outpatient surgical suite in Albany |

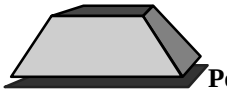


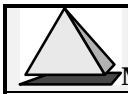
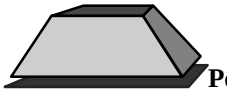
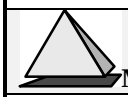
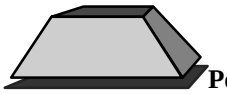
**Mission Goal:** Excellence in Service as Defined by Our Customers

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Increase Customer Satisfaction** | • Provide Kaset extraordinary customer service training for employees<br>• Provide targeted training to improve patient/provider satisfaction and communication<br>• Provide 360 degree evaluations for all physicians and primary care practitioners<br>• Implementation of a network clinic cancellation policy<br>• Design a method to improve cycle time for clinical consults within and between facilities<br>• Expand pager program for patients |



**Mission Goal:** Excellence in Education and Research

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Better Quality** | • Increase to 99 percent the proportion of research projects that are demonstrably related to the healthcare of veterans<br>• When asked, 95 percent of physician house staff and other trainees rate VA experience as good or superior to other academic training<br>• Increase to 2 percent, or 40 hours per year, the amount of an employee's paid time that is spent in continuing education to promote and support quality improvement or customer service |
| **Increase Alternate Revenue Streams** | • Increase total peer-review research funding<br>• Foster pharmaceutical industry-sponsored clinical trials through the Research Entrepreneurial Group (REG) |

| | |
|---|---|
|  **Mission Goal:** Be an Organization that is Characterized by Exceptional Accountability | |
|  **Operating Strategies** |  **Performance Goals** |
| **Better Quality** | • Implement practitioner profiling; continued focus on staff education in the areas of substance abuse; clinical practice guidelines; customer service education, and group therapy<br>• Review critical care processes and identify two major service deliveries to be reengineered<br>• Investment in data systems to support provider profiling, data analysis, and measurements |
| **Increase Alternate Revenue Streams** | • Increase the percentage of the operating budget received from non-appropriated sources to 10 percent by 2002<br>• Increase MCCF collections; pursue entrepreneurial ventures<br>• Pursue selection as Medicare network pilot site. |
|  **Mission Goal:** Be an Employer of Choice | |
|  **Operating Strategies** |  **Performance Goals** |
| **Be a Learning Organization** | • Increase to 100 percent the number of employees able to describe how their work meets the mission of the "New VA"<br>• Review and revitalize the employee suggestion program |
| **Continuing Education for VA Employees** | • Continue reengineering of the rewards and recognition program<br>• Provide Malcolm Baldrige training<br>• Training for clinical care and the use of commercial software packages |
| **Network Safety Initiatives** | • 20 percent reduction in Occupational Work Compensation Program incidents |

## 1997 SELECTED ACCOMPLISHMENTS

- Reduced cost per patient by five percent since '96
- Net increase of over 3,800 new Category A patients
- Initiated toll-free, centralized access to primary care
- Successfully initiated pilot for veteran health resource center at Elmira
- Opened CBOC at Binghamton
- Obtained congressional approval for CBOCs at Niagara Falls and Glens Falls
- All network clinics made primary care appointments in less than 30 days
- Improvement in Chronic Disease Index implementation from 44 percent in '96 to 77 percent
- Improvement in Prevention Index implementation from 35 percent in '96 to 74 percent
- In the 1997 National Survey Report for Recently Discharged Patients, improved in seven of nine measures; met or exceeded the national average in five of nine measures
- Achieved a 21 percent rating for CSS problems reported per patient which is better than the VA national average of 22 percent
- Network 2 is one of only three networks to have no decreases in customer satisfaction, and is performing at or better than the national average in four of the five categories
- Designed and implemented a National Customer Service Education Toolbox
- Committed funding to a clinical based outcome center in Syracuse, in partnership with the University of Syracuse
- Joint ventured with Marquette to use the ICU as a development lab for cutting edge ICU monitoring resulted in Albany VAMC receiving $1 million in free, state-of-the-art ICU monitors and computers
- Implemented the 360 degree performance evaluation for network office staff and ELC members
- Established two-tiered measurement system that provides both operational data (Pulse Points) and quality indicators (Balanced Scorecard)
- Creation of an Internet/Intranet web site that allows access to key information about the network, including access points with maps and directions, veteran and employee services, and other VA links
- Development of an employee recognition and reward program to support new behaviors
- Violence in the Workplace Training Program, originated at Albany, exported to other medical centers
- An education partnership between the Binghamton CBOC and the State University of New York created a primary care rotation for residents and medical students
- Implemented 22 clinical practice guidelines
- Met emergent needs on a 24-hour-a-day basis
- Conducted customer surveys at the medical centers under the guidance of the Customer Service Council
- Expanded Greeter Program to all medical centers
- Improved patient care through the review of various service models, including Planetree
- Developed clinic cancellation policy for the network
- Installed telecommunications equipment providing tele-pathology capability in VISN's three tertiary care hospitals & teleconferencing in five VISN medical centers

***Information as of December 12, 1997. The financial and workload information presented in this package is currently under review for use in budget justifications submitted to Congress.***

**BUDGETARY DATA SET (VISN 2)** **Table B-1**

| | 1997 Base | 1998 Tactical | 1999 Strategic | 2000 Strategic | 2001 Target | 2002 Target | 2003 Target |
|---|---|---|---|---|---|---|---|
| **1. Financial ($'s in thousands):** | | | | | | | |
| a. Medical Care, Sources of Funding: | | | | | | | |
| VERA Allocation for Medical Care | $433,558 | $416,824 | $403,011 | $403,011 | $403,011 | $403,011 | $403,011 |
| MCCR Collection [See Note] | $0 | $19,000 | $21,287 | $21,980 | $22,327 | $22,673 | $23,020 |
| Medicare Reimbursement | $0 | $0 | $0 | $0 | $15,000 | $18,000 | $21,000 |
| Tricare Collection | $0 | $400 | $420 | $445 | $455 | $465 | $465 |
| Other Sharing/Reimbursements | $2,656 | $2,922 | $3,214 | $3,535 | $3,889 | $4,278 | $4,705 |
| Planned Unobligated Balances | | | | | | | |
| **Total = Allocation + Revenues** | $436,214 | $439,146 | $427,932 | $428,971 | $444,682 | $448,427 | $452,201 |
| b. Percent Revenues to Allocation + Revenues | 0.61% | 5.08% | 5.82% | 6.05% | 9.37% | 10.13% | 10.88% |
| c. Distribution of Funding by selected activities: | | | | | | | |
| Acute Hospital Care | $130,864 | $122,961 | $111,262 | $111,532 | | | |
| Outpatient Care | $143,951 | $162,484 | $175,452 | $184,458 | | | |
| Long-Term Care | $65,432 | $65,872 | $64,190 | $64,346 | | | |
| Total | $340,247 | $351,317 | $350,904 | $360,336 | | | |
| **2. Federal Employment:** | | | | | | | |
| Average Employment (FTE), Total | 5,715 | 5,286 | 4,980 | 4,840 | | | |
| **3. Unique Patient Users (PRPs): [Unduplicated at the National Level]** | | | | | | | |
| a. Total Unique Patient Users (PRPs) | 82,152 | 92,152 | 95,152 | 96,652 | 98,152 | 99,652 | 101,152 |
| Percent Increase/Decrease from 1997 Base | | 12.17% | 15.82% | 17.65% | 19.48% | 21.30% | 23.13% |
| b. Distribution of PRPs by Eligibility Category: | | | | | | | |
| Category A | 66,543 | 74,643 | 77,073 | 78,288 | | | |
| Category C | 7,394 | 8,294 | 8,564 | 8,699 | | | |
| Non-Veteran Users | 8,215 | 9,215 | 9,515 | 9,665 | | | |
| Total | 82,152 | 92,152 | 95,152 | 96,652 | | | |
| c. Distribution of PRPs by VERA Patient Groups: | | | | | | | |
| Special Care Unique Patient Users | 4,284 | 4,805 | 4,962 | 5,040 | | | |
| Basic Care Unique Patient Users | 77,868 | 87,347 | 90,190 | 91,612 | | | |
| Total | 82,152 | 92,152 | 95,152 | 96,652 | | | |
| **4. Workload Episodes:** | | | | | | | |
| a. Outpatient Visits (Staff & Fee) | 948,337 | 998,397 | 882,085 | 763,612 | | | |
| b. Acute Hospital Care: | | | | | | | |
| Acute Hospital Beds | 431 | 415 | 435 | 442 | | | |
| Acute Hospital ADC | 417 | 374 | 391 | 398 | | | |
| Acute Inpatients Treated | 13,415 | 15,048 | 15,538 | 15,783 | | | |
| c. Long-Term Care: | | | | | | | |
| Long-Term Beds | 1,025 | 869 | 856 | 845 | | | |
| Long-Term ADC | 1,075 | 1,076 | 1,102 | 1,115 | | | |
| Long-Term Inpatients Treated | 3,145 | 3,528 | 3,643 | 3,700 | | | |
| **5. Number of Facilities:** | | | | | | | |
| VA Hospitals | 6 | 6 | 6 | 6 | | | |
| VA Nursing Home Care Units | 6 | 6 | 6 | 6 | | | |
| VA Domiciliaries | 2 | 2 | 2 | 2 | | | |
| Outpatient Clinics: | | | | | | | |
| Hospital Based, Independent & Mobile | 1 | 1 | 1 | 1 | | | |
| CBOCs, CBCs, Satellite & Outreach | 9 | 16 | 18 | 18 | | | |
| **6. Financial Measures (Medical Care):** | | | | | | | |
| a. Obligations Per Unique User Analysis (30% network goal): | | | | | | | |
| Obligations Per Unique User | $5,310 | $4,765 | $4,497 | $4,438 | $4,531 | $4,500 | $4,471 |
| Percent Change from 1997 Base | | -10.26% | -15.31% | -16.42% | -14.67% | -15.25% | -15.80% |
| Assumed Portion Current Services | | 3.75% | 7.63% | 11.63% | 15.45% | 19.92% | 24.28% |
| Percent Change Net of Current Services | | -14.01% | -22.94% | -28.05% | -30.12% | -35.17% | -40.08% |
| b. % Change in Unique Patient Users from 1997 base, from line 2a. above (20% network goal) | | 12.17% | 15.82% | 17.65% | 19.48% | 21.30% | 23.13% |
| c. % Revenues to Allocation + Revenues, from line 1b. above (10% network goal) | 0.61% | 5.08% | 5.82% | 6.05% | 9.37% | 10.13% | 10.88% |
| d. % of Acute Hosp.$s to Tot.of Acute $s + OP $s | 47.62% | 43.08% | 38.81% | 37.68% | | | |
| e. Outpatient Visits Per Unique User | 11.54 | 10.83 | 9.27 | 7.90 | | | |
| f. Med. Care Capital Obligations Per Unique User | $247 | $245 | $236 | $231 | | | |

# VA NEW YORK/NEW JERSEY NETWORK (NETWORK 3)
PLAN SUMMARY

## VISN OVERVIEW

A full range of services is provided by six medical centers for the veterans residing in the far eastern portion of New York and all of New Jersey. The estimated 1997 veteran population is 1,405,800. This network is unique in that all of its medical centers are within a 60-mile radius. The close location has made possible facility integrations such as East Orange/Lyons and the recently approved integration of Montrose and Castle Point.

## PLAN HIGHLIGHTS

| | |
|---|---|
| ***Quality*** | • Meet the VHA best outpatient performance for twelve targeted procedures<br>• Demonstrate at least a 50 percent improvement on chosen key aspects of the practice guidelines in ischemic heart disease, diabetes, and major depressive disorder<br>• Assess feasibility of providing a van for mobile mammography services network-wide<br>• Implement national clinical practice guidelines |
| ***Performance Measurement System*** | • Improve waiting time for spinal cord injury inpatient admissions |
| ***Customer Service*** | • Match average non-VA benchmark performance on overall satisfaction on the 1998 CSS Survey of ambulatory patients<br>• Achieve a 10 percent improvement on overall satisfaction of inpatients<br>• Assure 90 percent or more patients can answer "yes" when asked if there is one provider or team in charge of their care |

| | |
|---|---|
| ***Primary Care/Case Management*** | • Ensure that a single care manager is assigned to monitor and guide patient care across all settings, including the home<br>• Establish a Preventive Medicine/Health Promotion Council network-wide<br>• Increase the number of veterans provided home health services<br>• Pilot a Wellness Center at each facility to centralize specific prevention/health promotion procedures |
| ***Special Emphasis Programs and Six Disabling Conditions*** | • Implement a Spinal Cord Injury Service Line<br>• Maintain the network's record of achievement for waiting time for routine services for SCI patients<br>• Explore the feasibility of re-establishing a traumatic brain injury program at Northport VAMC<br>• Reduce the waiting time for orthopedics by 25 percent to 21 days<br>• Reduce waiting time for rehabilitation medicine by 25 percent to eight days<br>• Assure 70 percent or more of discharged patients for mental health disorders receive outpatient care within 30 days following discharge<br>• Assure ASI rating done on 90 percent of patients with active substance abuse diagnosis<br>• Refine the Intensive Case Management model for seriously mentally ill patients developed by the Northport facility |
| ***Community Based Outpatient Clinics (CBOCs)*** | Location — Date<br>Yonkers, NY — FY 1998<br>Elizabeth, NJ — FY 1998<br>Kingston, NY (Joint w/ VISN 2) — FY 1998<br>Jersey City, NJ — FY 1998<br>New Brunswick, NJ — FY 1998<br><br>Six additional sites will be submitted in FY98 (three of the six should be operational in FY98 bringing the total number to eight CBOCs activated during FY98) |
| ***Community Based Care Initiatives*** | • Activate six Community Based Outpatient Clinics in FY 1999 (three from FY 1998). Some potential areas of consideration are Long Island, Queens and New Jersey<br>• Activate five (unnamed) Community Based Outpatient Clinics in FY 2000<br>• Establish alternative residential and treatment settings for long term seriously mentally ill patients, including inpatient rehabilitation programs and community residency programs<br>• Increase number of veterans provided home health services |
| ***Service Lines*** | • Regionalize service lines, Phase II, for SCI, Prosthetics, Radiation Therapy, Surgery, Mental Health, Pharmacy, and Physical Medicine |
| ***Improving Clinical and Administrative Information Systems*** | • Complete the competency/training for teleradiology to ensure that all users are qualified to provide distance image readings<br>• Phase in supplemental teleradiology for Lyons, Bronx, and Castle Point facilities<br>• Finish implementing the Decision Support System in VA Hudson Valley and VA New Jersey |

| | |
|---|---|
| ***Communication*** | • Develop major educational initiative in cultural and communication issues in the provision of clinical care, including attitudes, behavior, interaction skills, and competency in spoken English<br>• Conduct continuous network-wide customer satisfaction surveys using a nationally recognized independent survey organization<br>• Implement a communications model in which each hospital based Public Affairs Officer develops a network level specialty |
| ***Education*** | • Assure that 50 percent of employees receive 20 hours of continuing education in improving the quality of their work<br>• Assure that 75 percent of patients with the appropriate diagnosis are offered relevant educational tapes |
| ***Research*** | • Increase to 99 percent the proportion of research projects that are demonstrably related to the healthcare of veterans or to other missions of the Department of Veterans Affairs |
| ***Sharing Agreements*** | • Offer ACLS/BCLS training to outside institutions |
| ***Contracting Services*** | • Analyze excess space for possible enhanced use, leasing, etc<br>• Contract out laboratory services previously performed by VA Central Dental Laboratory<br>• Investigate possibilities for providing laundry services to other organizations |
| ***Managing Human Resources*** | • Increase use of nurse practitioners and physician assistants<br>• Continue the residency reallocation process as outlined in the Petersdorf Report |
| ***Facility and/or Service Consolidations*** | • Develop plan for Bronx facility to provide surgical services for the Hudson Valley Healthcare System |
| ***Emergency Preparedness*** | • Maintain network capacity to respond to regional or national emergencies |


## NETWORK STRATEGIC PLAN SUMMARY

| | |
|---|---|
| **Mission Goal:** Clinical Quality | |
| **Operating Strategies** | **Performance Goals** |
| **Adopt a Care Management Model with a Single Care Manager** | • Identify and train sufficient numbers of staff to provide one for each primary care team<br>• By the end of '98 have a care manager assigned for each primary care team |
| **Implement the Regionalization Phase of Service Line Orientation** | • Integrate Rehabilitation and Physical Medicine services at Hudson Valley and New Jersey Healthcare System sites<br>• Develop plan to effect a consolidation of surgical services at Bronx and Hudson Valley<br>• Integrate the mental health nursing staff from the New Jersey Healthcare System<br>• Integrate psychology and psychiatry service staff at VAMC Brooklyn |
| **Implement Chronic Disease Management and Prevention Initiatives** | • Achieve a Chronic Disease Index (CDI) score of 90 percent or higher<br>• Achieve a Prevention Index (PI) score of 90 percent or higher |
| **Mission Goal:** Patient and Staff Safety | |
| **Operating Strategies** | **Performance Goals** |
| **Implement Proactive Risk Management** | • Identify a critical process of care and redesign delivery system where applicable<br>• Redesign two major service delivery systems at all VISN facilities identified as problematic<br>• Reduce the number of employees injured as measured by the lost time claims rate |

**Mission Goal:** Improve Access

| Operating Strategies | Performance Goals |
|---|---|
| **Increase Category-A Users** | • Increase the market penetration for Category A users by 1.24 percent |
| **Increase the Number of CBOCs** | • Have three additional CBOCs operational (submit six) '98<br>• Submit proposals for an additional six CBOCs '99 |
| **Place Added emphasis on Community Based Healthcare Services** | • Complete specifications for a network-wide RFP and sign contract for network-wide home care services '98<br>• Increase veterans in home care served by 5 percent |

**Mission Goal:** Address Needs of Special Emphasis Groups

| Operating Strategies | Performance Goals |
|---|---|
| **Address the needs of SCI patients** | • Improve waiting time for inpatient admission to same day<br>• Maintain Network's achievement for waiting times for SCI outpatient services |
| **Address the Needs of Blind Patients** | • Maintain or improve '97 achievements in optometry waiting times<br>• Continue the VICTORS program |
| **Address the Needs of TBI Patients** | • Maintain the level of immediate access to all patients with TBI requiring service<br>• Explore the feasibility of a TBI program at Northport |
| **Address the Needs of Amputees** | • Maintain the 0 percent delayed order rate<br>• Reduce wait time for orthopedics by 25 percent<br>• Reduce wait time for physical medicine and rehabilitation |
| **Address the Needs of Seriously Mentally Ill Patients** | • 70 percent or more of patients discharged will be provided outpatient care within 30 days<br>• Develop pilot project to identify SC veterans using other VA facilities<br>• Increase access to intensive care management/psychiatric rehabilitation<br>• Emphasize recovery-based and self-help interventions |

| | |
|---|---|
| **Address the Needs of Seriously Mentally Ill Substance Abuse Patients** | • 40 percent or more of SMI/substance abuse patients discharged will receive outpatient care within 30 days<br>• Reduce the average number of days to first outpatient substance abuse service to 26 days<br>• An ASI rating will be done on 90 percent of patients with active substance abuse as primary or secondary diagnosis<br>• Obtain Addiction Severity Index (ASI) on 90 percent or more of patients available for follow up |
| **Address the Needs of Homeless Seriously Mentally Ill Patients** | • Equal or exceed national performance goal of psychiatric outpatient visit within 30 days<br>• Increase number of veterans acquiring secure housing to the national goal<br>• Widen outreach to homeless veterans<br>• Increase the number of contracts for residential care<br>• Expand the Compensated Work Therapy program |
| **Address the needs of PTSD Seriously Mentally Ill Patients** | • Continue to improve access to PTSD services<br>• Co-locate primary care treatment sites at Vet Centers |

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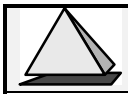
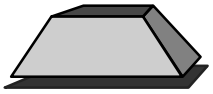
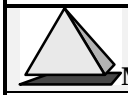
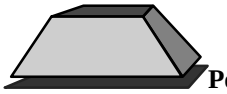
<tr><td colspan="2">  Mission Goal: Improve Information Management and Communication</td></tr>
<tr><td>  Operating Strategies</td><td>  Performance Goals</td></tr>
<tr><td>Implement Computerized Patient Record System (CPRS)<br><br>Augment/support data network infrastructure, video conferencing and telemedicine</td><td>• Establish an implementation team at each facility and have a team representative present for the CPRS deployment at the initial sites<br>• Begin migration to CPRS VAMC New York<br>• Begin migration to CPRS at Northport<br><br>• Fully deploy in '98 data networks in order to support Information Technology (IT) needs<br>• Install video-conferencing system at all sites<br>• Pilot video telemedicine at two sites in ‘98</td></tr>
<tr><td colspan="2">  Mission Goal: Improve Efficiency</td></tr>
<tr><td>  Operating Strategies</td><td>  Performance Goals</td></tr>
<tr><td>Consolidate Services<br><br>Decrease Bed Days of Care and Maintain Occupancy Levels</td><td>• Decide on whether to consolidate food services<br>• Explore further laboratory consolidations including outsourcing<br><br>• Reduce bed days of care per 1000 patients to the 1998 projected local Medicare rate for short stay hospital or the 1997 VA national average, whichever is lower<br>• Adjust operating beds to assure 85 percent hospital occupancy and 95 percent in NH/Domiciliaries</td></tr>
</table>

**Mission Goal:** Generate Revenue

| Operating Strategies | Performance Goals |
|---|---|
| **Emphasize Sharing Agreements** | • Establish a Sharing Council to advocate for additional sharing relationships, to direct development and to monitor progress<br>• Develop VISN-wide sharing agreement with Fort Monmouth, NJ; West Point, NY; and other Army, Navy and Air Force operations<br>• Pursue additional sharing agreements involving textile care<br>• Increase VISN-wide MCCR collections between $4 and $6 million<br>• Pilot software for PayVA<br>• Complete VISN-wide DSS implementation |

## 1997 SELECTED ACCOMPLISHMENTS

- Developed a network-wide service line for prosthetic services
- Developed a network-wide SCI service line plan
- Integrated rehabilitation and physical medicine services at Brooklyn and New York VAMCs
- Eliminated inpatient surgery at Castle Point
- Administratively integrated the psychiatrists, psychologists, mental health based social workers, and vocational rehabilitation staff, homeless services and domiciliary staff at the New Jersey system
- Opened a Mental Health Patient Care Center at the Bronx
- Integrated psychology and psychiatry service staff at VAMC New York
- Established a VISN Pharmacy and Therapeutics Committee
- Increased outpatient cardiac catheterizations to 45 percent
- Reduced surgical ALOS (Bronx by 12 percent; Brooklyn by 34 percent; New York by nine percent; and Northport by 13 percent)
- Increased telephone triage calls by 250 percent
- Increased gross revenue from sharing agreements by $683,797
- Decreased operating beds by 23.6 percent
- Increased the number of women veterans served by 5.9 percent
- Reduced VISN staffing through increased efficiencies
- All but one VAMC has created 23-hour observation
- Reduced BDOC to 3.5 percent lower than the projected FY97 HCFA rate for the region
- Enhanced homeless veterans' access to services
- Expanded VA-community partnerships
- Consolidated all textile care processing

***Information as of December 12, 1997. The financial and workload information presented in this package is currently under review for use in budget justifications submitted to Congress.***

**BUDGETARY DATA SET (VISN 3)** **Table B-1**

| | 1997 Base | 1998 Tactical | 1999 Strategic | 2000 Strategic | 2001 Target | 2002 Target | 2003 Target |
|---|---|---|---|---|---|---|---|
| **1. Financial ($'s in thousands):** | | | | | | | |
| a. Medical Care, Sources of Funding: | | | | | | | |
| VERA Allocation for Medical Care | $1,017,094 | $968,040 | $921,663 | $881,332 | $881,332 | $881,332 | $881,332 |
| MCCR Collection [See Note] | $0 | $43,705 | $49,092 | $79,798 | $84,798 | $90,302 | $95,720 |
| Medicare Reimbursement | $0 | $0 | $0 | $0 | $20,000 | $24,000 | $30,000 |
| Tricare Collection | $0 | $500 | $1,000 | $1,500 | $2,000 | $2,500 | $3,000 |
| Other Sharing/Reimbursements | $1,527 | $2,264 | $3,396 | $5,094 | $7,641 | $11,462 | $12,500 |
| Planned Unobligated Balances | $0 | ($39,335) | $9,181 | $25,073 | $5,091 | $0 | $0 |
| **Total = Allocation + Revenues** | $1,018,621 | $975,174 | $984,332 | $992,797 | $1,000,862 | $1,009,596 | $1,022,552 |
| b. Percent Revenues to Allocation + Revenues | 0.15% | 4.77% | 5.43% | 8.70% | 11.43% | 12.70% | 13.81% |
| c. Distribution of Funding by selected activities: | | | | | | | |
| Acute Hospital Care | $296,179 | $287,294 | $278,675 | $270,315 | | | |
| Outpatient Care | $351,509 | $365,569 | $380,192 | $395,400 | | | |
| Long-Term Care | $99,927 | $100,926 | $101,936 | $102,955 | | | |
| Total | $747,615 | $753,789 | $760,803 | $768,670 | | | |
| **2. Federal Employment:** | | | | | | | |
| Average Employment (FTE), Total | 11,960 | 11,951 | 11,566 | 10,568 | | | |
| **3. Unique Patient Users (PRPs): [Unduplicated at the National Level]** | | | | | | | |
| a. Total Unique Patient Users (PRPs) | 148,030 | 153,433 | 159,033 | 164,838 | 170,855 | 177,091 | 179,924 |
| Percent Increase/Decrease from 1997 Base | | 3.65% | 7.43% | 11.35% | 15.42% | 19.63% | 21.55% |
| b. Distribution of PRPs by Eligibility Category: | | | | | | | |
| Category A | 114,387 | 118,562 | 122,889 | 127,375 | | | |
| Category C | 11,289 | 12,495 | 13,745 | 15,042 | | | |
| Non-Veteran Users | 22,354 | 22,376 | 22,399 | 22,421 | | | |
| Total | 148,030 | 153,433 | 159,033 | 164,838 | | | |
| c. Distribution of PRPs by VERA Patient Groups: | | | | | | | |
| Special Care Unique Patient Users | 10,309 | 10,440 | 10,573 | 10,707 | | | |
| Basic Care Unique Patient Users | 137,721 | 142,993 | 148,460 | 154,131 | | | |
| Total | 148,030 | 153,433 | 159,033 | 164,838 | | | |
| **4. Workload Episodes:** | | | | | | | |
| a. Outpatient Visits (Staff & Fee) | 1,878,697 | 1,947,066 | 2,018,134 | 2,091,796 | | | |
| b. Acute Hospital Care: | | | | | | | |
| Acute Hospital Beds | 760 | 737 | 715 | 694 | | | |
| Acute Hospital ADC | 610 | 591 | 574 | 556 | | | |
| Acute Inpatients Treated | 20,333 | 19,723 | 19,132 | 18,558 | | | |
| c. Long-Term Care: | | | | | | | |
| Long-Term Beds | 1,357 | 1,343 | 1,330 | 1,317 | | | |
| Long-Term ADC | 2,204 | 2,182 | 2,160 | 2,138 | | | |
| Long-Term Inpatients Treated | 3,188 | 3,156 | 3,124 | 3,093 | | | |
| **5. Number of Facilities:** | | | | | | | |
| VA Hospitals | 6 | 6 | 6 | 6 | | | |
| VA Nursing Home Care Units | 5 | 5 | 5 | 5 | | | |
| VA Domiciliaries | 3 | 3 | 3 | 3 | | | |
| Outpatient Clinics: | | | | | | | |
| Hospital Based, Independent & Mobile | 11 | 13 | 14 | 15 | | | |
| CBOCs, CBCs, Satellite & Outreach | 5 | 13 | 19 | 24 | | | |
| **6. Financial Measures (Medical Care):** | | | | | | | |
| a. Obligations Per Unique User Analysis (30% network goal): | | | | | | | |
| Obligations Per Unique User | $6,881 | $6,356 | $6,189 | $6,023 | $5,858 | $5,701 | $5,683 |
| Percent Change from 1997 Base | | -7.63% | -10.06% | -12.47% | -14.87% | -17.15% | -17.41% |
| Assumed Portion Current Services | | 3.75% | 7.63% | 11.63% | 15.45% | 19.92% | 24.28% |
| Percent Change Net of Current Services | | -11.38% | -17.69% | -24.10% | -30.32% | -37.07% | -41.69% |
| b. % Change in Unique Patient Users from 1997 base, from line 2a. above (20% network goal) | | 3.65% | 7.43% | 11.35% | 15.42% | 19.63% | 21.55% |
| c. % Revenues to Allocation + Revenues, from line 1b. above (10% network goal) | 0.15% | 4.77% | 5.43% | 8.70% | 11.43% | 12.70% | 13.81% |
| d. % of Acute Hosp.$s to Tot.of Acute $s + OP $s | 45.73% | 44.01% | 42.30% | 40.61% | | | |
| e. Outpatient Visits Per Unique User | 12.69 | 12.69 | 12.69 | 12.69 | | | |
| f. Med. Care Capital Obligations Per Unique User | $444 | $387 | $267 | $265 | | | |

# VA STARS & STRIPES HEALTHCARE NETWORK (NETWORK 4)
PLAN SUMMARY

## VISN OVERVIEW

The network geographically includes 63 of 67 counties in Pennsylvania, Delaware, 7 of 21 counties in New Jersey, and portions of West Virginia, Maryland, Ohio, and New York. The network maintains relationships with over 11 medical colleges, providing access to numbers of private sector entities. The network faces many challenges in its environment, from a declining population base to static or minimally increasing appropriations and an aggressively competitive private healthcare sector. The veterans served by the network are increasingly elderly. The estimated FY97 veteran population was 1,673,100.

## PLAN HIGHLIGHTS

| | |
|---|---|
| ***Quality*** | • Assess and promote quality care through measurable indicators<br>• Identify and develop data elements which measure clinical activity and health outcomes for certain disease entities<br>• Establish benchmarks and standards comparable with the private sector to measure quality, clinical practice patterns, resource utilization and/or outcomes of care<br>• Optimize distribution of services across the Network by using '97 clinical inventory for current service locations<br>• Develop standard policy for utilization of cardiac stress testing practices |
| ***Performance Measurement System*** | • Implement network-specific performance measures:<br>⇒ Average cost/patient<br>⇒ Continuity of care<br>⇒ Continuity of provider<br>⇒ Customer relations<br>⇒ Non-appropriated funds<br>⇒ Network coordination (QA) |
| ***Customer Service*** | • Focus on retaining as well as attracting new users<br>• Provide tools to promote a successful network-wide marketing program<br>• Enhance image and awareness of network<br>• Increase customer satisfaction and retention |

| | |
|---|---|
| ***Primary Care/Case Management*** | • Fully implement a clinical case management system across the network and enroll 75 percent of appropriate patients by FY00<br>• Drop readmission rates by 50 percent over FY97 rate<br>• Strengthen primary care delivery system<br>• By FY00, increase the number of patients who see the same primary care provider or team at all visits by 100 percent over FY98 baseline<br>• Activate Ambulatory Care/Environmental Improvements project now under construction at Wilkes-Barre |
| ***Special Emphasis Programs and Six Disabling Conditions*** | • Continue to host annual VA/community homelessness assessment, local education and networking group to conduct needs assessment at Wilkes-Barre<br>• Propose environmental improvements at Pittsburgh (UD) to provide quality inpatient facilities that will contribute to customer satisfaction |
| ***Community Based Outpatient Clinics (CBOCs)*** | • Clarion, Armstrong, Lawrence Counties, PA; Willow Grove Naval Air Station, PA; Aliquippa, PA; Seaford, DE; Crawford County, PA; McKean County, PA; Ashtabula County, PA; Greensburg, PA; Schuylkill County, PA; Tobyhanna, PA; Clearfield County, PA; Centre County, PA; Fort Dix, NJ; Berks; Lancaster; Schuylkill; York County; McKeesport; Cape May, NJ ('98)<br>• Fayette County, PA; Carbondale, PA; Washington County, PA; McCandless; Monroeville; Bloomsburg, PA ('99) |
| ***Service Lines*** | • Establish a Network Information Technology Service Line |
| ***Improving Clinical and Administrative Information Systems*** | • Ensure information systems link outcomes, financial performance and patient information throughout the VISN<br>• Establish a telecommunications system for information exchange that is patient specific<br>• Enhance current video conferencing and telemedicine applications<br>• Accelerate implementation of DSS<br>• Pilot a patient bedside clinical information system<br>• Fully implement electronic medical record<br>• Develop a Network Business Office to assemble, analyze and distribute a balanced scorecard |
| ***Communication*** | • Enhance communication vehicles which provide timely information to employees across the network and ensure that 100 percent of employees receive timely, relevant communication<br>• Fully implement targeted marketing programs to increase users by at least 5 percent over FY97, 10 percent in FY98 & 15 percent in FY00<br>• Strategic Planning Board has VSO representative |
| ***Education*** | • Network educational plan focuses on retraining and developing multi-skilled workforce<br>• Develop and implement system-wide employee training programs utilizing a planned “virtual learning university”<br>• Implementing 50 percent of recommended changes of Residency Realignment Review Committee to further reduce appropriate house staff by about 16 positions |

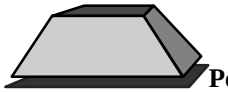
| | |
|---|---|
| ***Research*** | • All network facilities will be reimbursed for individual investigator and co-investigator salaries proportional to their involvement in specific veterans' issues |
| ***Sharing Agreements*** | • Expand partnerships with government and private sector programs, increase other non-appropriated revenues by $2,000,000 over FY97, and another $2,000,000 in both FY99 and FY00 |
| ***Contracting Services*** | • Implement network-wide consolidated procurement and contracting to maximize procurement savings while maintaining quality patient care |
| ***Managing Human Resources*** | • Focus on enhancing the network culture through employee recognition, communication, and supporting employees through change and aligning employee education with network strategies |
| ***Facility and/or Service Consolidations*** | • Explore consolidations of network laboratory operations<br>• Implement network-wide pharmacy Consolidated Mail-Out Program (CMOP)<br>• Consolidate MCCR activities, (all or part) within network<br>• Reduce pathology costs by $1.5 M through standardization of lab test results for clinical consistency throughout network |
| ***Emergency Preparedness*** | • Emergency Medical Preparedness Advisory Council established to provide oversight<br>• Establish an Emergency Medical Response Team to respond to disasters |

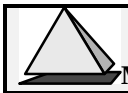

## NETWORK STRATEGIC PLAN SUMMARY

**Mission Goal:** Excellence in Healthcare Value

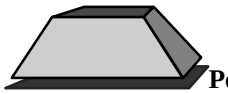
| Operating Strategies | Performance Goals |
|---|---|
| **Enhance the Quality and Timeliness of Behavioral Health Sciences** | **'98:** 25 percent of patients receiving SSRIs for depressive or anxiety disorders, "atypical" antipsychotics for schizophrenia or schizo-affective disorder will be monitored for efficacy and/or tolerability of these drugs<br>**'99:** 50 percent will be monitored<br>**'00:** 75 percent will be monitored |
| **Increase Operations Efficiency by Implementing an Enrollment Based Resource Allocation Model** | **'98:** Produce network operating margin of $15,000,000<br>**'99:** Produce network operating margin of $15,000,000<br>**'00:** Produce network operating margin of $15,000,000 |

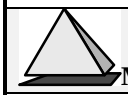
**Mission Goal**: Excellence in Service as Defined by Customers

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Improve Patient/Family/Clinician Shared Decision Making** | **'98:** Each Health Services Council subcommittee will implement formal patient/family/clinician shared decision-making in one clinical area<br>**'99:** Network will achieve 20 percent improvement from baseline performance on monitoring of shared decision-making in clinical areas selected in '98<br>**'00:** Network will achieve a 45 percent improvement over '98 |
| **Increase Customer Satisfaction and Retention** | **'98:** Equal non-VHA benchmark scores on the five applicable CSS measured by NACCSS<br>**'99:** Exceed non-VHA benchmark scores on two of CSS measured by NACCSS; equal non-VHA benchmark scores on the other three CSS<br>**'00:** Exceed non-VHA benchmark scores on four of the applicable CSS; equal non-VHA benchmark score on the other CSS |

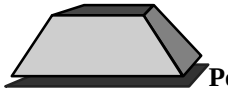


**Mission Goal:** Excellence in Education and Research

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Promote Mutually Beneficial Relationships Between the Network and its Academic Affiliates** | **'98:** All physician house staff to determine baseline rating as to whether experience was as good, or superior to, other academic training<br>**'99:** Each facility in which the network physician house staff did not rate experience as good as, or superior to other training, will improve rating by 25 percent of difference between rating in '98 and '02 target goal of 95 percent<br>**'00:** Each facility in which 95 percent of staff did not rate experience as good as, or superior to, their other training will improve rating by 33 percent of difference between '00 and '02 target of 95 percent |
| **Link Research Initiatives with Veterans Needs Performance Goals** | **'98:** Initiate at least one opportunity for research linked to special patient care groups<br>**'99:** Initiate at least one new network research effort focused on veterans' needs identified in health needs assessment and common DRGs<br>**'00:** Implement at least one additional network-wide research initiative |



**Mission Goal**: Be an Organization Characterized by Exceptional Accountability

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Increase MCCR Collections** | **'98:** By seven percent based on '97<br>**'99:** By nine percent based on '98<br>**'00:** By nine percent based on '99 |
| **Re-engineer Network Information Management Delivery System** | **'99:** Refine the network information technology product line<br>**'00:** Refine and complete a network information technology product line |

**Mission Goal:** Be an Employer of Choice

| Operating Strategies | Performance Goals |
|---|---|
| **Recognize and Reward Employees Who Contribute to the Network's Success** | **'98:** 70 percent of employee performance rewards and recognition programs are aligned with achievement of organizational goals and reflect accountability<br>**'99:** 80 percent are aligned<br>**'00:** 90 percent are aligned |
| **Provide Employee Education in Line with the Network's Goals and Strategies** | **'98:** Develop partnerships with at least four councils and groups to produce successful educational activity<br>**'99:** Through partnering, identify and collaborate with other network groups to provide six network educational offerings<br>**'00:** Develop one alternate revenue source that can be used to generate funds to support network education |

## 1997 SELECTED ACCOMPLISHMENTS

- Increased users by 20,000
- Seven of 10 network facilities assigned 100 percent of patients to primary care provider or team
- Educated patients on how primary care system works
- Developed patient information packets on how to access their provider
- Two new CBOCs established
- Established partnership with community provider to provide primary care to Wilkes-Barre and Lebanon veterans
- Seven facilities implemented evening and/or weekend hours for primary care
- Network coordination and alignment of pathology services will get $1.8 M annual savings
- Reduced network staff by nine percent
- Decreased obligations per user by 10 percent
- Drug costs per user declined by >two percent
- Laboratory costs per user reduced by >12 percent
- All facilities performed 50 percent of procedures on ambulatory basis
- Each facility designated marketing coordinator
- All academic affiliations were renegotiated, placing stronger emphasis on primary care
- Achieved 100 percent of Category II-IV reductions for academic year '97/'98
- 50 percent of house staff positions in primary care
- 95 percent of house staff express satisfaction with training experience
- Most facilities have revised employee performance standards to ensure consistency with network performance agreement and have strong focus on customer service
- Focused on aligning employee incentives and performance management system with network's goals and customer service
- Implemented network-wide Utilization Management Policy
- Increased usage of purchase card program (over 90 percent utilization at most facilities)
- Held network-wide Marketing Education and Training Conference
- Majority of facilities have reduced their re-admission rate
- Network has established Centers of Excellence in behavioral health (dual diagnosis), substance abuse, long term care, transplants, prosthetics, and occupational issues
- Increased operational efficiencies creating $12 million in savings which were used to fund the personnel buyout program and new initiatives

***Information as of December 12, 1997. The financial and workload information presented in this package is currently under review for use in budget justifications submitted to Congress.***

**BUDGETARY DATA SET (VISN 4)** **Table B-1**

| | 1997 Base | 1998 Tactical | 1999 Strategic | 2000 Strategic | 2001 Target | 2002 Target | 2003 |
|---|---|---|---|---|---|---|---|
| **1. Financial ($'s in thousands):** | | | | | | | |
| a. Medical Care, Sources of Funding: | | | | | | | |
| VERA Allocation for Medical Care | $778,814 | $774,619 | $774,619 | $774,619 | $774,619 | $774,619 | |
| MCCR Collection [See Note] | $0 | $35,986 | $33,722 | $36,659 | $40,418 | $44,111 | |
| Medicare Reimbursement | $0 | $0 | $0 | $0 | $25,298 | $27,587 | |
| Tricare Collection | $0 | $260 | $947 | $1,399 | $2,484 | $3,544 | |
| Other Sharing/Reimbursements | $2,316 | $6,317 | $9,843 | $12,971 | $16,981 | $19,918 | |
| Planned Unobligated Balances | | ($5,009) | ($3,305) | $2,992 | | | |
| **Total = Allocation + Revenues** | $781,130 | $812,173 | $815,826 | $828,640 | $859,800 | $869,779 | $0 |
| b. Percent Revenues to Allocation + Revenues | 0.30% | 5.24% | 5.46% | 6.16% | 9.91% | 10.94% | |
| c. Distribution of Funding by selected activities: | | | | | | | |
| Acute Hospital Care | $212,091 | $214,461 | $215,377 | $208,401 | | | |
| Outpatient Care | $260,136 | $299,463 | $316,121 | $345,500 | | | |
| Long-Term Care | $308,903 | $303,258 | $287,633 | $271,747 | | | |
| Total | $781,130 | $817,182 | $819,131 | $825,648 | | | |
| **2. Federal Employment:** | | | | | | | |
| Average Employment (FTE), Total | 9,767 | 9,473 | 9,332 | 9,202 | | | |
| **3. Unique Patient Users (PRPs): [Unduplicated at the National Level]** | | | | | | | |
| a. Total Unique Patient Users (PRPs) | 148,670 | 156,103 | 163,537 | 170,970 | 178,404 | 185,837 | |
| Percent Increase/Decrease from 1997 Base | | 5.00% | 10.00% | 15.00% | 20.00% | 25.00% | -100.00% |
| b. Distribution of PRPs by Eligibility Category: | | | | | | | |
| Category A | 132,688 | 139,322 | 145,956 | 152,591 | | | |
| Category C | 8,786 | 9,226 | 9,665 | 10,104 | | | |
| Non-Veteran Users | 7,196 | 7,555 | 7,916 | 8,275 | | | |
| Total | 148,670 | 156,103 | 163,537 | 170,970 | | | |
| c. Distribution of PRPs by VERA Patient Groups: | | | | | | | |
| Special Care Unique Patient Users | 10,716 | 12,248 | 13,606 | 17,319 | | | |
| Basic Care Unique Patient Users | 137,954 | 143,855 | 149,931 | 153,651 | | | |
| Total | 148,670 | 156,103 | 163,537 | 170,970 | | | |
| **4. Workload Episodes:** | | | | | | | |
| a. Outpatient Visits (Staff & Fee) | 1,557,380 | 1,639,447 | 1,699,210 | 1,751,399 | | | |
| b. Acute Hospital Care: | | | | | | | |
| Acute Hospital Beds | 1,029 | 953 | 906 | 897 | | | |
| Acute Hospital ADC | 746 | 775 | 767 | 752 | | | |
| Acute Inpatients Treated | 27,227 | 27,400 | 27,030 | 26,438 | | | |
| c. Long-Term Care: | | | | | | | |
| Long-Term Beds | 2,148 | 2,124 | 2,137 | 2,137 | | | |
| Long-Term ADC | 1,949 | 1,904 | 1,943 | 1,934 | | | |
| Long-Term Inpatients Treated | 2,647 | 2,483 | 2,497 | 2,578 | | | |
| **5. Number of Facilities:** | | | | | | | |
| VA Hospitals | 12 | 12 | 12 | 12 | | | |
| VA Nursing Home Care Units | 10 | 10 | 11 | 11 | | | |
| VA Domiciliaries | 3 | 3 | 3 | 3 | | | |
| Outpatient Clinics: | | | | | | | |
| Hospital Based, Independent & Mobile | 14 | 14 | 14 | 14 | | | |
| CBOCs, CBCs, Satellite & Outreach | 37 | 58 | 64 | 68 | | | |
| **6. Financial Measures (Medical Care):** | | | | | | | |
| a. Obligations Per Unique User Analysis (30% network goal): | | | | | | | |
| Obligations Per Unique User | $5,254 | $5,203 | $4,989 | $4,847 | $4,819 | $4,680 | |
| Percent Change from 1997 Base | | -0.97% | -5.04% | -7.75% | -8.28% | -10.93% | |
| Assumed Portion Current Services | | 3.75% | 7.63% | 11.63% | 15.45% | 19.92% | 24.28% |
| Percent Change Net of Current Services | | -4.72% | -12.67% | -19.38% | -23.73% | -30.85% | |
| b. % Change in Unique Patient Users from 1997 base, from line 2a. above (20% network goal) | | 5.00% | 10.00% | 15.00% | 20.00% | 25.00% | -100.00% |
| c. % Revenues to Allocation + Revenues, from line 1b. above (10% network goal) | 0.30% | 5.24% | 5.46% | 6.16% | 9.91% | 10.94% | |
| d. % of Acute Hosp.$s to Tot.of Acute $s + OP $s | 44.91% | 41.73% | 40.52% | 37.62% | | | |
| e. Outpatient Visits Per Unique User | 10.48 | 10.50 | 10.39 | 10.24 | | | |
| f. Med. Care Capital Obligations Per Unique User | $446 | $478 | $343 | $252 | | | |

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# VA CAPITOL NETWORK (NETWORK 5)
PLAN SUMMARY

## VISN OVERVIEW

The VA Capitol Network occupies an economically and demographically diverse area of four states (Maryland, West Virginia, Virginia and Pennsylvania) and the District of Columbia. Demand for care is greatest in the cities and in the rural counties of West Virginia and Southern-Maryland. As expected, the majority of the user-population resides close to the provider facilities. The estimated FY97 veteran population is 818,400. Network 5 is a demographically highly diverse area, embracing some of the most affluent (Fairfax County, VA and Montgomery County, MD) and least well-off communities (inner cities of Baltimore and Washington; rural districts of Southern Maryland and West Virginia) in the United States.

## PLAN HIGHLIGHTS

| | |
|---|---|
| ***Quality*** | • Emphasize managed care services (primary and preventive care, case management, shared decision-making); identify and treat medical conditions earlier<br>• Expand case management to ensure quality care in appropriate settings<br>• Use best practices to provide local facilities with guidelines for prioritizing steps for quality services<br>• Relocate outpatient clinics to former inpatient areas at Washington, DC to improve efficiency of existing outpatient clinics<br>• Maximize effectiveness of human resources available to the network<br>• Increase the value of care – high quality at reasonable cost<br>• Increase by 10-15 percent in years 2 and 3 the amount of appropriate surgery done in an ambulatory care setting; perform 90 percent of appropriate surgery in an ambulatory care setting within 5 years |
| ***Performance Measurement System*** | • Use local performance measures to monitor planning initiatives in such areas as length of stay, establishment of CBOCs, managed care initiatives, employee education, consistency in care delivery, primary care enrollment, mental illness, and others<br>• Continue improvement of performance measures (national and local)<br>• In the long-term, the network will develop performance measures that are more focused on medical outcomes<br>• Increase case management to reduce admissions and length of stay<br>• Increase primary care enrollment 5-10% over 1997 in years 2 and 3 |

| | |
|---|---|
| | • Achieve 95 percent primary care enrollment within 5 years<br>• Continue improvement of chronic disease and prevention indices<br>• Exceed by 10 percent the proportion of patients of other large healthcare providers who achieve maximal functional potential<br>• Increase to 100 percent the proportion of research projects that are demonstrably related to the healthcare of veterans or to other missions of the VA<br>• Decrease acute bed days of care 5-10 percent over 1997 each year in years 2 and 3; achieve 1300 Bed Days of Care/1000 patients within 5 years<br>• Plan to increase to 90 percent the proportion of patients reporting VA healthcare as very good or excellent within 2-3 years; increase to 95 percent the proportion of patients who rate the quality of healthcare as equivalent to or better than what they would receive from any other healthcare provider within 5 years; increase to 75 percent the proportion of patients reporting they would choose the VA as their preferred healthcare provider if they had unrestricted choice of who provides healthcare within 5 years |
| ***Customer Service*** | • Give customer service awards at each site in the network and one quarterly network goal award to the individual or group making significant contributions in support of network goals<br>• Evaluate customer service training class for presentation at all network sites<br>• Engage an external consultant to present a train-the-trainer program on customer service at two facilities<br>• Organize a VISN customer service best practices task force to identify the essential elements for VISN-wide customer service<br>• Meet private sector customer satisfaction scores<br>• Improve the patient transportation system<br>• Facilitate customer service related communication, which provides support and guidance to the facilities as they implement VISN customer service best practices and develop customer service plans<br>• Enhance the visibility and importance of customer service by combining resources<br>• Improve techniques for defining and exceeding the patient/customer expectation of services<br>• Provide opportunities for veterans to have an active role and participate in customer service development, implementation and evaluation<br>• Renovate and improve aesthetics: Washington, DC surgical suite, outpatient area, patient privacy, and general aesthetics; Perry Point psychiatric bed building |

| | |
|---|---|
| ***Primary Care/Case Management*** | • The VA Capitol Network is a health delivery system based on a primary care model<br>• Reduce non-acute admissions by focusing on primary care and health promotion by increasing primary care outpatients by approximately 10 percent per year<br>• Improve the opportunities for effective patient education and tracking by establishing primary care screening and education standards that can be enforced in the revised clinic settings<br>• Renovate laboratory area at Martinsburg and Washington, DC to handle outpatient workload more efficiently<br>• Primary care space funds for at least some facility improvements to primary care space are included in the capital plan, for example, in Washington, DC expand primary care - $245,000<br>• Provide feedback on selected parameters to primary care providers<br>• New modes of ambulatory primary care delivery include contracts with individual providers, co-location with Vet Centers, establishment of freestanding primary care and multi-specialty clinics<br>• Renovate existing inpatient space at Washington, DC and Martinsburg to expand outpatient space to effectively deal with increased outpatient workload generated by CBOCs and marketing efforts<br>• Of 243.5 medical resident positions, 112.5 (46 percent) are in primary care<br>• By FY 1999, the network plans to increase the percentage of primary care physicians to 53 percent and the primary care medical resident positions to 53 percent |
| ***Special Emphasis Programs and Six Disabling Conditions*** | • The network will explore and develop plans to keep special emphasis programs viable through sharing agreements<br>• Establish network-wide long-term care admission and discharge criteria and screening processes<br>• Expand use of clinical guidelines (Implement 12-14 nationally developed guidelines, two of which are for Special Emphasis populations)<br>• Establish a Mental Health Advisory Committee to ensure quality, consistency, and efficiency across the network<br>• Continue service line implementation plans in Mental Health and Geriatrics and Extended Care<br>• Avoid making any change that would decrease capacity to treat these special patients. |
| ***Community Based Outpatient Clinics (CBOCs)*** | Locations — Fiscal Year<br>Hagerstown MD — '98<br>Charlotte Hall MD — '98<br>Fairfax VA — '98 |
| ***Community Based Care Initiatives*** | • Conduct follow-up in the community rather than in the hospital setting in the context of operating community–based health care services<br>• Evaluate the transportation system for cost effectiveness and make needed changes to better serve the veteran |

| | |
|---|---|
| ***Service Lines*** | Currently Evaluating:<br>• Mental Health<br>• Pathology/Laboratory<br>• Geriatrics and Extended Care<br>• Acquisitions and Material Management<br><br>Other Possibilities Include:<br>• Employee Education<br>• Information Management (including telemedicine/teleradiology)<br>• Human Resources/Fiscal<br>• Pharmacy |
| ***Improving Clinical and Administrative Information Systems*** | • Ensure appropriate staff are trained in DSS, input data into DSS databases, operationalize DSS throughout the network and utilize DSS data/information to aid in decision-making<br>• Further implement teleconferencing/telemedicine<br>• Provide ability to access other ADP systems in VISN<br>• Ensure each facility has implemented current VISTA packages to the fullest extent<br>• Fully integrate VISN databases with assistance from National Database Integration Team<br>• Coordinate implementation of Network Health Exchange<br>• Beta test CIRN, if approved<br>• Expand use of a wide variety of telemedicine information technology<br>• Test VISTA Imaging, which initially incorporates radiographic, MRI, CT, and ultrasound images in Baltimore and Washington, DC VAMCs<br>• Use computer radiographic equipment at Perry Point and Martinsburg to capture radiographic images for local and VISN use<br>• Develop a network-wide electronic medical record |
| ***Communication*** | • Integrate efforts in related goals with marketing and public affairs<br>• Slides of the Network Strategic Plan and Performance Measure standings are discussed during the Employee Open Forum portion of the Network Director's quarterly site visit to each facility<br>• Publish quarterly newsletter covering network activities |

| | |
|---|---|
| ***Education*** | • Develop education on cultural change, communication skills, computer skills, interpersonal skills, and team training<br>• Partially centralize education efforts through the Network Education Board to ensure consistency and quality of education<br>• Provide network-wide educational opportunities for patients via an interactive computer network<br>• Continue to utilize the present video-teleconferencing units for remote classroom sessions to expand employee educational opportunities<br>• Conduct a needs assessment of all employees, and receive better than 70% response rate. Education Board to develop strategies based on evaluation of results<br>• Promote/expand Education Board to oversee network education needs<br>• For '97, the VISN set a goal of having 75-90 percent of all employees receive a minimum of 16 hours of education on performance measurement and exceeded that goal, reaching 91 percent. The number of hours will be increased each year until the ultimate goal of having every employee receive 40 hours of relevant education is reached<br>• Develop a "Help Yourself Program" to assist employees in taking responsibility for future career tracks |
| ***Research*** | • Increase total peer-reviewed research funding<br>• Increase to 100% the proportion of research projects that are demonstrably related to the healthcare of veterans or to other missions of the Department of Veterans Affairs<br>• Geriatric Research and Education Clinical Center at Baltimore Medical Center, VAMHCS leads the way in all aspects of geriatric research from health services to bench science research<br>• Continue our research success in partnership with the five academic affiliates<br>• Ensure that clinical programs will have adequate space to support their mission of research |

| | |
|---|---|
| ***Sharing Agreements*** | • Evaluate consolidation/sharing of services with other federal facilities (e.g., DoD, NIH, etc.) and implement where appropriate |
| ***Contracting Services*** | • Establish contracts with potential partners to generate revenue streams<br>• Consolidate contracting for reagents and reference testing<br>• Establish contracts with potential partners to generate revenue streams for mental health<br>• Implement central procurement activity<br>• Evaluate and expand centralization of contracting services as appropriate |
| ***Managing Human Resources*** | • Evaluate appropriate mix and utilization of staff<br>• Increase number of nurse practitioners and physician assistants<br>• Decrease total number of physicians<br>• Establish a "help yourself" career tract. A contact person at each medical center will be available to guide employees to the resources needed to enhance opportunities for promotion, career change, self-improvement, training, and/or job search information.<br>• Review models for staffing mental health delivery at all levels utilizing physician extenders where appropriate |
| ***Facility and/or Service Consolidations*** | • Evaluate for consolidation of services network-wide and implement as needed<br>• Evaluate medical specialties for consolidation |
| ***Emergency Preparedness*** | • VA Capitol Network is committed to providing support during Department of Defense and domestic emergencies |

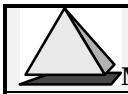

## NETWORK STRATEGIC PLAN SUMMARY

**Mission Goal:** Improve the Value of Our Services

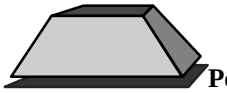
| Operating Strategies | Performance Goals |
|---|---|
| **Reduce Inappropriate Admissions and Lengths of Stay** | **'98-99:** Increase case management<br>**'98-99:** Improve community-based health care services<br>**'98-99:** Enhance UM program |
| **Develop Additional Forms of Effective and Efficient Care Delivery, including Sub-acute Beds, Long Term Care, Residential Settings, and Increased Outpatient Services** | **'98-99:** Identify at least two potential CBOC locations per year<br>**'98-03:** Expand telemedicine capabilities throughout network<br>**'98-99:** Operationalize CBOCs within six months of approval<br>**'98-03:** Continue to work with Vet Centers to increase outpatient services<br>**'98-03:** Identify additional technologies/opportunities to provide care closer to veterans' homes |

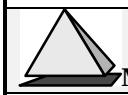
**Mission Goal:** Promote Managed Care

| Operating Strategies | Performance Goals |
|---|---|
| **Appropriate Mix and Utilization of Staff** | **'98-99:** Increase number of nurse practitioners and physician assistants<br>**'98-03:** Decrease total physicians |
| **Establish Standards of Care** | **'98-03:** Further implement shared decision-making<br>**'98-99:** Develop primary care screening and education standards of care that can be enforced<br>**'98-99:** Monitor those standards of care<br>**'03:** Improve upon those standards of care not being met |

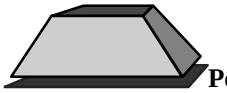


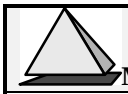
**Mission Goal:** Define and Implement Selected Areas of Clinical Focus

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Areas of Clinical Excellence** | **'98-99:** Mental health at Perry Point Division, VAMCS<br>**'98-99:** Domiciliary at Martinsburg<br>**'98-99:** Substance Abuse network-wide |
| **Mental Health** | **'98-99:** Continue to revise formulary<br>**'98-99:** Improve follow-up after hospitalization for mental illness<br>**'98-99:** Expand the use of the Addiction Severity Index |
| **Pathology** | **'98-99:** Continue to standardize on-site testing instrumentation<br>**'98-99:** Continue to consolidate tests<br>**'98-99:** Continue to consolidate contracting for reagents and reference testing<br>**'98-99:** Continue to evaluate consolidation/sharing of testing with other federal facilities<br>**'98-99:** Evaluate high technology initiatives (e.g., telepathology)<br>**'98-99:** Achieve core lab, if appropriate |

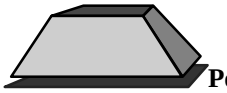


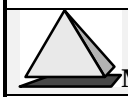
**Mission Goal:** Achieve Operational Efficiencies

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Implement DSS** | **'98-99:** Continue to input data into DSS databases<br>**'98-99:** Operationalize DSS throughout the network<br>**'98-03:** Utilize DSS data/information to aid in decision making |
| **Information Management** | **'98-99:** Beta test CIRN, if approved<br>**'98-03:** Fully integrate VISN databases with assistance from National Database Integration Team<br>**'98-03:** Develop a Network-wide electronic medical record |

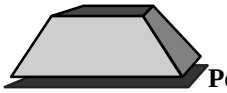


**Mission Goal:** Recruit New Veteran Users

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Customer Satisfaction** | **'98-99:** Meet private sector satisfaction scores<br>**'03:** Increase to 90 percent the proportion of patients reporting VA healthcare as very good or excellent<br>**'03:** Increase to 95 percent the proportion of patients who rate the quality of health care as equivalent to or better than what they would receive from any other healthcare provider |
| **Improve Waiting Times** | **'98-99:** Implement additional after-hours and weekend clinics |



**Mission Goal:** Develop New Sources of Revenue

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Increase the Number of New Revenue Sources** | **'98-03:** VA/DOD and CHAMPUS/TriCare, etc.<br>**'98-03:** Mental Health Offering<br>**'98-03:** Laundry Initiative<br>**'98-03:** Medicare Demonstration Project |

## 1997 SELECTED ACCOMPLISHMENTS

- Implemented consistent UM program
- Expanded pre-admission diagnostic testing
- Submitted three CBOC proposals
- Instituted case management
- Implemented telemedicine
- Adjusted acute bed levels as needed
- Partially developed primary care screening and education standards
- Decreased physician staff and increased nurse practitioners and physician assistants
- Developed a coordinated VISN credentialing process
- Decreased specialization by increasing ratio of primary care physicians to specialists. While the number of physicians has been reduced to 315, the percent of those trained in primary care has increased to 29 percent
- Developed consistent network guidelines/protocols on eligibility
- Developed and implemented a truly consolidated telephone liaison program
- Increased number of patients enrolled in primary care
- Improved on Chronic Disease and Prevention Indices
- Developed network admission and continued stay criteria
- Implemented nationally developed clinical practice guidelines
- Developed a comprehensive model of mental health services
- Revised formulary
- Revised staffing models
- Initiated discussions with potential partners to generate revenue streams
- Developed pathology utilization guidelines
- Partially trained staff in DSS
- Partially input data into DSS databases
- Initial computer integration implemented (e.g., ability to sign onto other systems in VISN, current VISTA packages implemented in Network)
- Coordinated implementation of Network Health Exchange
- Improved waiting times
- Implemented patient transportation system
- Established call-back program
- Developed initiatives for VA/DOD, mental health offering, and laundry initiative
- Competed to be one of the sites selected for the Medicare demonstration project
- Involved staff at all levels in the planning task forces to promote positive, informed change
- Began conducting follow-up in the community rather than in a hospital setting
- Consolidated bed units with low ADC
- Began working with Vet Centers to increase outpatient services
- Developed consistent network policy on access to treatment
- Created Education Board to oversee network education needs
- New Psychiatric Patient Building at VAMC Perry Point
- Seven minor construction projects throughout Network to improve patient care
- Strengthened Special Emphasis Programs by meeting network and headquarters measures
- Centralized contracting for service lines

- Centralized transportation service for service lines
- Centralized construction planning/implementation for service lines
- Centralized equipment purchases >$50,000 for service lines
- Formed task forces to evaluate services within the Network and made recommendations to consolidate, realign and/or redesign services and functions
- Adjusted level of operating beds within Network as needed
- Expanded ambulatory surgery as needed to meet/exceed performance measures (58-70 percent of appropriate surgery)
- Increased utilization of temporary lodging
- Implemented a virtual A&MMS section for central contracting for leases, nursing homes, halfway houses, preventive maintenance services and supply contracts >$25,000
- Implemented consolidated admissions/eligibility criteria for Long Term Care patients
- Began coordination of screening process among facilities for referred patients for Long Term Care
- Implemented specialty surgery recommendations of the Surgical Task Force
- Long Term Mental Health focus established at Perry Point (mission change)
- Implemented teleconferencing
- Initiated utilization of CMOP at Murfreesboro for all facilities in network
- Implemented additional after hours and weekend clinics
- Increased the number of hours of education to at least 16 hours per employee

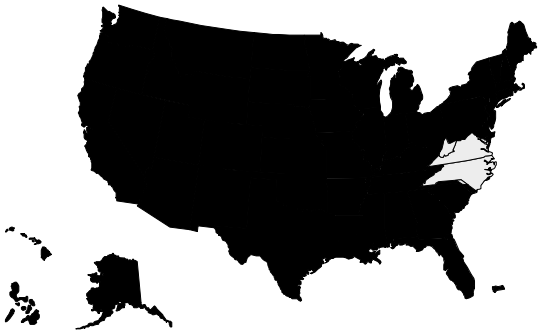
***Information as of December 12, 1997. The financial and workload information presented in this package is currently under review for use in budget justifications submitted to Congress.***

**BUDGETARY DATA SET (VISN 5)** **Table B-1**

| | 1997 Base | 1998 Tactical | 1999 Strategic | 2000 Strategic | 2001 Target | 2002 Target | 2003 Target |
|---|---|---|---|---|---|---|---|
| **1. Financial ($'s in thousands):** | | | | | | | |
| a. Medical Care, Sources of Funding: | | | | | | | |
| VERA Allocation for Medical Care | $442,000 | $456,535 | $456,535 | $456,535 | $456,535 | $456,535 | $456,535 |
| MCCR Collection [See Note] | $0 | $21,126 | $23,239 | $25,562 | $28,119 | $30,931 | $32,477 |
| Medicare Reimbursement | $0 | $0 | $0 | $0 | $11,247 | $15,465 | $16,239 |
| Tricare Collection | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Other Sharing/Reimbursements | $1,455 | $1,705 | $1,955 | $2,075 | $2,200 | $2,325 | $2,450 |
| Planned Unobligated Balances | | ($17,754) | ($12,264) | $1,710 | $5,667 | $16,490 | $29,599 |
| **Total = Allocation + Revenues** | $443,455 | $461,612 | $469,465 | $485,882 | $503,768 | $521,746 | $537,300 |
| b. Percent Revenues to Allocation + Revenues | 0.33% | 4.95% | 5.37% | 5.69% | 8.25% | 9.34% | 9.52% |
| c. Distribution of Funding by selected activities: | | | | | | | |
| Acute Hospital Care | $165,505 | $170,470 | $175,584 | $180,852 | | | |
| Outpatient Care | $162,034 | $178,237 | $186,257 | $194,639 | | | |
| Long-Term Care | $57,977 | $59,716 | $61,508 | $63,353 | | | |
| Total | $385,516 | $408,423 | $423,349 | $438,844 | | | |
| **2. Federal Employment:** | | | | | | | |
| Average Employment (FTE), Total | 5,688 | 6,219 | 6,249 | 6,281 | | | |
| **3. Unique Patient Users (PRPs): [Unduplicated at the National Level]** | | | | | | | |
| a. Total Unique Patient Users (PRPs) | 82,111 | 87,038 | 92,260 | 97,796 | 102,663 | 107,883 | 113,277 |
| Percent Increase/Decrease from 1997 Base | | 6.00% | 12.36% | 19.10% | 25.03% | 31.39% | 37.96% |
| b. Distribution of PRPs by Eligibility Category: | | | | | | | |
| Category A | 69,794 | 73,982 | 78,421 | 83,127 | | | |
| Category C | 5,748 | 6,397 | 7,120 | 7,925 | | | |
| Non-Veteran Users | 6,569 | 6,659 | 6,719 | 6,744 | | | |
| Total | 82,111 | 87,038 | 92,260 | 97,796 | | | |
| c. Distribution of PRPs by VERA Patient Groups: | | | | | | | |
| Special Care Unique Patient Users | 4,252 | 4,302 | 4,331 | 4,380 | | | |
| Basic Care Unique Patient Users | 77,859 | 82,736 | 87,929 | 93,416 | | | |
| Total | 82,111 | 87,038 | 92,260 | 97,796 | | | |
| **4. Workload Episodes:** | | | | | | | |
| a. Outpatient Visits (Staff & Fee) | 916,488 | 977,891 | 991,235 | 1,004,768 | | | |
| b. Acute Hospital Care: | | | | | | | |
| Acute Hospital Beds | 589 | 560 | 530 | 500 | | | |
| Acute Hospital ADC | 398 | 396 | 394 | 392 | | | |
| Acute Inpatients Treated | 17,744 | 18,099 | 18,461 | 18,830 | | | |
| c. Long-Term Care: | | | | | | | |
| Long-Term Beds | 830 | 830 | 830 | 830 | | | |
| Long-Term ADC | 1,153 | 1,153 | 1,153 | 1,153 | | | |
| Long-Term Inpatients Treated | 2,684 | 2,684 | 2,684 | 2,684 | | | |
| **5. Number of Facilities:** | | | | | | | |
| VA Hospitals | 5 | 5 | 5 | 5 | | | |
| VA Nursing Home Care Units | 4 | 4 | 4 | 4 | | | |
| VA Domiciliaries | 2 | 2 | 2 | 2 | | | |
| Outpatient Clinics: | | | | | | | |
| Hospital Based, Independent & Mobile | 5 | 5 | 5 | 5 | | | |
| CBOCs, CBCs, Satellite & Outreach | 3 | 6 | 9 | 12 | | | |
| **6. Financial Measures (Medical Care):** | | | | | | | |
| a. Obligations Per Unique User Analysis (30% network goal): | | | | | | | |
| Obligations Per Unique User | $5,401 | $5,304 | $5,088 | $4,968 | $4,907 | $4,836 | $4,743 |
| Percent Change from 1997 Base | | -1.80% | -5.80% | -8.02% | -9.15% | -10.46% | -12.18% |
| Assumed Portion Current Services | | 3.75% | 7.63% | 11.63% | 15.45% | 19.92% | 24.28% |
| Percent Change Net of Current Services | | -5.55% | -13.43% | -19.65% | -24.60% | -30.38% | -36.46% |
| b. % Change in Unique Patient Users from 1997 base, from line 2a. above (20% network goal) | | 6.00% | 12.36% | 19.10% | 25.03% | 31.39% | 37.96% |
| c. % Revenues to Allocation + Revenues, from line 1b. above (10% network goal) | 0.33% | 4.95% | 5.37% | 5.69% | 8.25% | 9.34% | 9.52% |
| d. % of Acute Hosp.$s to Tot.of Acute $s + OP $s | 50.53% | 48.89% | 48.53% | 48.16% | | | |
| e. Outpatient Visits Per Unique User | 11.16 | 11.24 | 10.74 | 10.27 | | | |
| f. Med. Care Capital Obligations Per Unique User | $494 | $349 | $231 | $221 | | | |

# VA MID-ATLANTIC NETWORK (NETWORK 6)
PLAN SUMMARY

## VISN OVERVIEW



VISN 6 was established to integrate the healthcare of eight Department of Veterans Affairs medical centers located in North Carolina, Virginia and West Virginia. The medical centers are separated by distances requiring one to five hours of driving time. The estimated FY97 veteran population is 1,196,300. The network includes two of the largest military complexes in the nation (Fort Bragg and Norfolk Naval Military Industrial Complex). Virginia and North Carolina have significant populations of active duty and retired military, potentially under-served by VA.

## PLAN HIGHLIGHTS

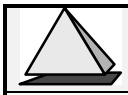
| | |
|---|---|
| ***Quality*** | • Initiate Provider Profiling<br>• Implement VAHQ's FY98 clinical practice guidelines and pathways/protocols<br>• Promote learning through Quality Improvement by providing each employee with training in QI<br>• Continue development of a balanced scorecard<br>• Use Baldridge criteria to measure continuous quality improvement<br>• Continue to improve cardiac cath program<br>• Improve continuity of care through daily VISTA communications |
| ***Performance Measurement System*** | • Application of Utilization Management Performance Monitors<br>• Establish data driven measurements of progress for four major elements: Patient Satisfaction, Employee Satisfaction, Health Status of Patients and Financial Performance<br>• Design a surgical renovation at Durham to improve efficiency<br>• Budget and financial performance measures will be developed and used |

| | |
|---|---|
| ***Customer Service*** | • Reduce customer complaints to below national non-VA benchmarks<br>• Appoint a network-wide QM coordinator for oversight of customer service<br>• Projects planned at Beckley to renovate wards to correct patient privacy deficiencies<br>• Provide customer service training<br>• Provide formalized customer service programs to be implemented at remaining VAMCs<br>• Provide communication skills training for providers and patients to facilitate shared decision-making<br>• Continue cooperative relationships between employees, unions, and VSOs |
| ***Primary Care/Case Management*** | • Implement service line management for primary care and preventive medicine in FY98<br>• Renovate medical centers to provide increased primary care space<br>• Increase primary care enrollment each year<br>• Emphasize the full implementation of case management throughout the network<br>• Replace and upgrade Spiral CT Scanner with 3D Modality at Durham<br>• Replace MRI unit at Richmond<br>• Renovations at Asheville and at Salisbury to provide increased ambulatory care space<br>• Implement case management |
| ***Special Emphasis Programs and Six Disabling Conditions*** | • Establish the Spinal Cord Injury & Disease Service Line in FY98<br>• Expand SEAT for Gulf War and other veterans<br>• Expand women veterans' programs at all VAMCs<br>• Implement Geriatrics and Long Term Care Service Line<br>• Commit more resources for the treatment of chronic mentally ill and PTSD patients<br>• Enhance access of low-vision services to blind veterans<br>• Renovate treatment and medical space serving chronically mentally ill and PTSD programs at Salisbury and Salem |
| ***Community Based Outpatient Clinics (CBOCs)*** | Locations / Fiscal Year: Charlotte, NC 1998; Greenville, NC 1998; Jacksonville, NC 1998; Danville, VA 1998; Hickory, NC 1999; Greensboro, NC 1999; Lynchburg, VA 1999; Petersburg, VA 1999<br>Locations / Fiscal Year: Wilmington NC 2000; Raleigh, NC 2000; Goldsboro, NC 2000; Fredericksburg, VA 2000; Franklin, NC 2000; 3 Other Sites 2001; 4 Other Sites 2002 |
| ***Community Based Care Initiatives*** | • Initiate Peer Administered Residence (PAR) Program for homeless<br>• Implement plan for Home Health Care<br>• Use health fairs and mobile health screenings or other outreach programs to identify annually potential new enrollees<br>• Develop plan for palliative care<br>• Provide two buildings (Salisbury) for use as NC State Veterans Homes through enhanced use legislation |

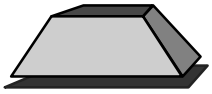
| | |
|---|---|
| ***Service Lines*** | • Phased implementation of service lines<br>• Assess impact of budgetary shifts on medical center allocations due to implementation of service lines<br>• Assess cost effectiveness of tertiary care activities in surgery<br>• Develop policy and procedure manuals for the three pilot service lines<br>• Produce informational brochures and newsletters pertaining to service lines |
| ***Improving Clinical and Administrative Information Systems*** | • Continue implementing innovations and initiatives in information systems and medical informatics<br>• Complete implementation of Decision Support System<br>• Implement CPRS<br>• Automate CPGs<br>• Automate Balanced Scorecard |
| ***Communication*** | • Commit at least one staff member at every VAMC for public affairs and external relations<br>• Publish a quarterly newsletter<br>• Publish a network brochure and a service line management brochure<br>• Provide strong staff and patient/family education regarding new enrollment benefits package |
| ***Education*** | • Strengthen the academic affiliation between Fayetteville VAMC and UNC-School of Medicine<br>• Strengthen the academic affiliation between VISN 6 and UNC- School of Public Health<br>• Initiate workplace safety education programs to reduce OWCP costs<br>• Publish a brochure summarizing changes occurring within VHA to assist our academic partners<br>• Obtain additional residency training positions in preventive medicine, occupational medicine and toxicology fellowship<br>• Establish joint medicine-psychiatry training program within the VISN for addiction medicine<br>• Utilize the Managed Care Institute of the UNC- School of Public Health to educate VISN staff<br>• Ensure 90 percent of employees are exposed to eligibility reform training annually |
| ***Research*** | • Increase research expenditures by five percent<br>• Protect research time for staff<br>• Host a network-wide research conference to collaborate on research projects<br>• Ensure research is patient focused<br>• Maintain AALAC accreditation for VA Animal Research Facilities<br>• Mentor new/young researchers |
| ***Sharing Agreements*** | • Seek additional VA/DOD sharing opportunities. |
| ***Contracting Services*** | • Become a preferred provider for Tri-Atlantic (DOD managed care contractor)<br>• Increase consolidated procurement contracts<br>• Assess the level of unofficial inventories among the medical centers<br>• Expand the Energy Savings Performance Contract (ESPC) through DOD to include additional VAMCs<br>• Contract for CBOC support |

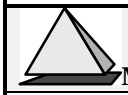
| | |
|---|---|
| ***Managing Human Resources*** | • Adopt performance-based interview techniques for recruitment of employees<br>• Continue emphasis on tuition support programs<br>• Teach new competencies (i.e., management/leadership skills) for service line leaders<br>• Link rewards, recognition and promotion to employee performance |
| ***Facility and/or Service Consolidations*** | • Consolidate contracting and standardize procurement of medical equipment and supplies<br>• Integrate appropriate clinical activities through use of telemedicine<br>• Establish Capital Assets & Investment Board for the network |
| ***Emergency Preparedness*** | • Continue to deploy the mobile clinics for assistance during natural disasters<br>• Support storage of EMPO supplies stockpiles |


## NETWORK STRATEGIC PLAN SUMMARY

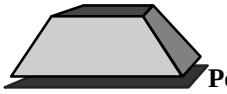


**Mission Goal:** Become an Integrated Healthcare Delivery System

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Improve Resource Management** | **'98:** Realign budgets to support service line reorganization<br>**'99:** Increase non-appropriated revenue by at least three percent<br>**'00:** Increase non-appropriated revenue by at least three percent |
| **Develop Provider Education Plan Focusing on Integrated Healthcare** | **'98:** Develop Managed Care Institute<br>**'99:** Ensure that 50 percent of medical care residents are trained in primary care<br>**'00:** Ensure that 50 percent of allied health trainees are exposed to primary care delivery |



**Mission Goal:** Ensure Provision of Cost Effective and High Quality Healthcare

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Promote Managed Care** | **'98:** Implement VAHQ's FY98 clinical practice guidelines (CPGs) and pathways/protocols<br>**'99:** Integrate provider profiling and CPG implementation through automation<br>**'00:** Initiate other VHA-developed guidelines |
| **Expand Primary Care Services** | **'98:** Expand primary care services and activate new CBOCs<br>**'99:** Incorporate mental health clinics with CBOCs and activate new CBOCs<br>**'00:** Link all Vet Centers with CBOCs |

**Mission Goal**: Promote a Shift from Hospital-Based to Community-Based Care

| Operating Strategies | Performance Goals |
|---|---|
| **Shift Focus of Healthcare Delivery to the Outpatient Setting** | **'98:** Establish four new CBOCs<br>**'99:** Establish four additional CBOCs<br>**'00:** Establish five additional CBOCs |
| **Decrease Inpatient Care** | **'98:** Reduce BDOC/1000 unique (acute care) users<br>**'99:** Decrease total operating beds by 60<br>**'00:** Decrease total operating beds by at least 30 |

**Mission Goal:** Strengthen VHA's Special Emphasis Programs

| Operating Strategies | Performance Goals |
|---|---|
| **Enhance Institutional and Non-Institutional Capacity to Serve Unmet SCI Needs** | **'98:** Implement SCI Service Line<br>**'99:** Enhance the provider skills and number of SCI Teams<br>**'00:** Expand community-based SCI long term care resources |
| **Ensure Continued Viability of all VHA Special Emphasis Programs** | **'98:** Expand Homeless initiatives<br>**'99:** Implement Geriatric and Extended Care Service Line<br>**'00:** Support State Nursing Homes in North Carolina through enhanced use legislation |

**Mission Goal:** Enhance Employee Satisfaction

| Operating Strategies | Performance Goals |
|---|---|
| **Provide a Safe and Friendly Workplace** | **'98:** Promote and foster ADR and team building<br>**'99:** Offer 40 hours of education for employees<br>**'00:** Ensure the presence of armed security police |
| **Promote Career Development Initiatives** | **'98:** Provide leadership training opportunities to mid-level personnel<br>**'99:** Promote 360-degree evaluation for personnel<br>**'00:** Link performance-based reward and recognition systems |

## 1997 SELECTED ACCOMPLISHMENTS

- Completed training for all occupational, safety & health personnel
- Completed ADR training
- Used team building at VAMC Fayetteville
- Successfully completed training for arming security police (Hampton and Richmond)
- Initiated phased implementation of three pilot service lines
- 89 percent of employees indicated knowledge of mission
- Assigned network-wide duties to VAMC triads
- Implemented 12 CPGs
- Implemented successful UR and RM programs
- Established additional primary care teams
- Established one CBOC (Tazewell, VA)
- Reduced BDOCs by 25 percent
- Reduced operating beds by 12 percent
- Imparted clinical training in SCI-primary care to teams at all VAMCs
- Established a dedicated inpatient unit (Salisbury) for women veterans
- Established telemedicine link in psychiatry between VAMC Salem and Beckley
- Number of unique veterans treated in primary care increased by more than 7 percent
- Developed a service line structure for primary care/preventive medicine
- Developed a service line structure for mental health/preventive medicine
- Reduced mental health operating beds by more than 21 percent
- Consolidated 180 geropsych beds with 120 extended care rehab beds to form a 300 bed geriatric program
- Developed a contracted residential care program for homeless veterans
- Employee training needs survey accomplished VISN-wide
- Implemented a remote psychiatric clinic at Beckley, WV staffed by the Salem VAMC
- 39 percent of all mental health patients treated were service-connected
- 47 percent of all veterans treated for psychosis were service-connected
- 60 percent of all veterans treated for PTSD were service-connected
- Identified SCI/D Primary Care Teams in VISN 6 at all VAMCs
- An agreement with DOD TriCare Military Region 2 Office will enable VISN 6 to provide care to eligible CHAMPUS beneficiaries
- Completed VISN's clinical service inventory and inventory of scarce medical resources
- Ambulatory Care Addition at VAMC Fayetteville completed in September, 1997
- VISN signed agreement with DOD to accomplish a VISN-wide energy savings contract
- VISN-wide affiliation with University of North Carolina School of Public Health established
- Joint education project with DOD and Fayetteville to provide a cooperative program to determine feasibility of educating masters degree prepared registered nurses to become nurse practitioners using distance learning capabilities

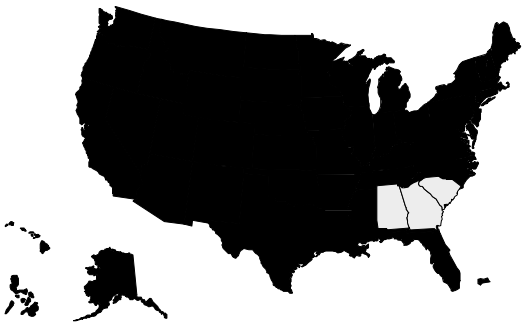
***Information as of December 12, 1997. The financial and workload information presented in this package is currently under review for use in budget justifications submitted to Congress.***

**BUDGETARY DATA SET (VISN 6)** **Table B-1**

| | 1997 Base | 1998 Tactical | 1999 Strategic | 2000 Strategic | 2001 Target | 2002 Target | 2003 |
|---|---|---|---|---|---|---|---|
| **1. Financial ($'s in thousands):** | | | | | | | |
| a. Medical Care, Sources of Funding: | | | | | | | |
| VERA Allocation for Medical Care | $706,758 | $698,194 | $698,194 | $698,194 | $698,194 | $698,194 | |
| MCCR Collection [See Note] | $0 | $39,909 | $46,168 | $51,873 | $57,315 | $62,708 | |
| Medicare Reimbursement | $0 | $0 | $0 | $9,000 | $9,500 | $10,000 | |
| Tricare Collection | $0 | $0 | $4,500 | $5,000 | $6,000 | $7,000 | |
| Other Sharing/Reimbursements | $4,600 | $4,750 | $5,500 | $6,000 | $6,250 | $6,500 | |
| Planned Unobligated Balances | $0 | $0 | $0 | $0 | $0 | $0 | |
| **Total = Allocation + Revenues** | $711,358 | $742,853 | $754,362 | $770,067 | $777,259 | $784,402 | $0 |
| b. Percent Revenues to Allocation + Revenues | 0.65% | 6.01% | 7.45% | 9.33% | 10.17% | 10.99% | |
| c. Distribution of Funding by selected activities: | | | | | | | |
| Acute Hospital Care | $332,841 | $330,998 | $325,298 | $320,652 | | | |
| Outpatient Care | $212,198 | $237,713 | $262,447 | $280,942 | | | |
| Long-Term Care | $62,315 | $66,857 | $69,361 | $72,134 | | | |
| Total | $607,354 | $635,568 | $657,106 | $673,728 | | | |
| **2. Federal Employment:** | | | | | | | |
| Average Employment (FTE), Total | 9,215 | 9,225 | 9,133 | 9,042 | | | |
| **3. Unique Patient Users (PRPs): [Unduplicated at the National Level]** | | | | | | | |
| a. Total Unique Patient Users (PRPs) | 164,230 | 169,978 | 175,726 | 182,295 | 192,149 | 201,500 | |
| Percent Increase/Decrease from 1997 Base | | 3.50% | 7.00% | 11.00% | 17.00% | 22.69% | -100.00% |
| b. Distribution of PRPs by Eligibility Category: | | | | | | | |
| Category A | 143,747 | 150,431 | 157,275 | 164,977 | | | |
| Category C | 2,763 | 2,685 | 2,601 | 2,516 | | | |
| Non-Veteran Users | 17,720 | 16,862 | 15,850 | 14,802 | | | |
| Total | 164,230 | 169,978 | 175,726 | 182,295 | | | |
| c. Distribution of PRPs by VERA Patient Groups: | | | | | | | |
| Special Care Unique Patient Users | 5,991 | 6,200 | 6,410 | 6,650 | | | |
| Basic Care Unique Patient Users | 158,239 | 163,778 | 169,316 | 175,645 | | | |
| Total | 164,230 | 169,978 | 175,726 | 182,295 | | | |
| **4. Workload Episodes:** | | | | | | | |
| a. Outpatient Visits (Staff & Fee) | 1,324,038 | 1,359,824 | 1,405,808 | 1,458,360 | | | |
| b. Acute Hospital Care: | | | | | | | |
| Acute Hospital Beds | 1,089 | 1,089 | 1,029 | 999 | | | |
| Acute Hospital ADC | 661 | 664 | 628 | 609 | | | |
| Acute Inpatients Treated | 27,569 | 27,236 | 25,735 | 24,985 | | | |
| c. Long-Term Care: | | | | | | | |
| Long-Term Beds | 1,357 | 1,357 | 1,357 | 1,357 | | | |
| Long-Term ADC | 1,729 | 1,737 | 1,751 | 1,764 | | | |
| Long-Term Inpatients Treated | 7,218 | 6,948 | 7,002 | 7,056 | | | |
| **5. Number of Facilities:** | | | | | | | |
| VA Hospitals | 8 | 8 | 8 | 8 | | | |
| VA Nursing Home Care Units | 8 | 8 | 8 | 8 | | | |
| VA Domiciliaries | 1 | 1 | 1 | 1 | | | |
| Outpatient Clinics: | | | | | | | |
| Hospital Based, Independent & Mobile | 9 | 9 | 9 | 9 | | | |
| CBOCs, CBCs, Satellite & Outreach | 11 | 15 | 19 | 24 | | | |
| **6. Financial Measures (Medical Care):** | | | | | | | |
| a. Obligations Per Unique User Analysis (30% network goal): | | | | | | | |
| Obligations Per Unique User | $4,331 | $4,370 | $4,293 | $4,224 | $4,045 | $3,893 | |
| Percent Change from 1997 Base | | 0.90% | -0.88% | -2.47% | -6.60% | -10.11% | |
| Assumed Portion Current Services | | 3.75% | 7.63% | 11.63% | 15.45% | 19.92% | |
| Percent Change Net of Current Services | | -2.85% | -8.51% | -14.10% | -22.05% | -30.03% | |
| b. % Change in Unique Patient Users from 1997 base, from line 2a. above (20% network goal) | | 3.50% | 7.00% | 11.00% | 17.00% | 22.69% | -100.00% |
| c. % Revenues to Allocation + Revenues, from line 1b. above (10% network goal) | 0.65% | 6.01% | 7.45% | 9.33% | 10.17% | 10.99% | |
| d. % of Acute Hosp.$s to Tot.of Acute $s + OP $s | 61.07% | 58.20% | 55.35% | 53.30% | | | |
| e. Outpatient Visits Per Unique User | 8.06 | 8.00 | 8.00 | 8.00 | | | |
| f. Med. Care Capital Obligations Per Unique User | $167 | $193 | $195 | $200 | | | |

# VA HEALTHCARE SYSTEM OF ATLANTA (NETWORK 7)
PLAN SUMMARY

## VISN OVERVIEW



The Atlanta Network includes the states of Alabama, Georgia, and South Carolina. Its estimated 1997 veteran population is 1,341,800. This network's healthcare delivery system is organized by clinical service lines. These service lines have been organized to improve access to quality healthcare and to "Ensure the Health and Well Being of Veterans" and to "Be the Health Plan of Choice" for veterans in Alabama, Georgia, and South Carolina. The Atlanta Network has acknowledged the need to address the needs of an increasing number of elderly veterans. It is now planning for additional service lines with an emphasis on extended care.

## PLAN HIGHLIGHTS

| | |
|---|---|
| ***Quality*** | • The Health Center for Quality Evaluation will design and implement a CQI program similar to the HCFA and HQIP programs and design and implement a QA and systems performance monitoring program.<br>• Implement a Provider Profiling Information System<br>• Develop specialized primary care quality monitors |
| ***Performance Measurement System*** | • The Health Services Evaluation staff is beginning to develop measures and systems for monitoring quality and performance. These will be further developed and implemented during FY '98<br>• Design and implement a Systems Performance Monitoring Program<br>• Benchmark performance against the performance of non-VA health care organizations |
| ***Customer Service*** | • Hire a Network Coordinator for the Customer Service/Customer Satisfaction Program and Enhanced Volunteer Assistance Program<br>• During FY 98-- Customer Service Standards training for all employees on selected standards<br>• Continue the development of the Network Customer Service/Customer Satisfaction Program and Enhanced Volunteer Assistance Program |

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| ***Primary Care/Case Management*** | • The Primary Care Service Line will focus on three main areas during '98, including expansion of access to care; primary care service improvements; and costing of primary care services<br>• Implement plan to transfer the responsibility for CBOCs, Community Service Programs (CSP), and independent outpatient clinics from the medical centers to the Primary Care Service Line<br>• Include mental health services, the expansion of the current CSPs, CBOCs and independent outpatient clinics in Alabama (to add either mental health or primary care to current services) in upcoming CBOC solicitations<br>• Geriatrics and Extended Care Service Line will pilot a rural health initiative identifying needs of the frail elderly and providing intervention using a case management model<br>• Place access points within one hour's drive of veterans in Network 7 to encourage early intervention<br>• Implement standardized patient panel sizes<br>• Establish primary care initiatives in telephone care |
| ***Special Emphasis Programs and Six Disabling Conditions*** | • Mental health services for special populations at CBOCs will include telemedicine services for mental health special emphasis patients<br>• Provision of substance abuse treatment for SCD veterans will be provided by the VAMC Augusta Mental Health Service Line<br>• Continue referral agreements for homeless veterans to be developed and sustained through VA staff participation in local homeless programs as well as VA staff participation to coordinate services for the homeless<br>• Identify veterans who have had a traumatic brain injury; and educate providers, patients and families regarding the availability of services within the VA TBI network<br>• Implement a hoptel with formal outpatient PTSD programs throughout the network contingent upon local needs/circumstances<br>• Enhance primary care for PTSD veterans with psychiatric or physical co-morbidities at all facilities and access points<br>• All CBOC current/planned catchment will be reviewed in terms of the number of PTSD veterans in need of treatment and services planned accordingly |
| ***Community Based Outpatient Clinics (CBOCs)*** | • All new CBOCs throughout the network will be accomplished under the direction of the Primary Care Service Line<br>• FY 98:Dothan, AL (implemented 12/97); Florence, SC; Myrtle Beach, SC; Macon, GA; Albany, GA - all approved. Northeast, GA has been submitted and is awaiting review and approval |
| ***Community Based Care Initiatives*** | • Continue to make home care available either through contract or in-house programs<br>• Continue to expand hospice care either in a VA medical center or through contract with community programs<br>• The CARE (Care and Assistance for Rural Elders) Program will assist families in maintaining patients in the home |

| | |
|---|---|
| ***Service Lines*** | • Service lines for mental health and primary care and information technology will be further implemented and developed<br>• Fund service line staff for '98 using a transitional model<br>• Service lines such as those within specialty and ancillary services, the business office, and stakeholder relations are now in their beginning planning processes (they include diagnostic medicine, geriatrics and extended care and stakeholder relations)<br>• The Primary Care Service Line will focus on expansion of access to care; primary care service improvements; and costing of primary care services in '98<br>• Decrease annual costs two percent per year per unique user through '02 for the mental health service line |
| ***Improving Clinical and Administrative Information Systems*** | • Implement teleradiology emphasizing its use by outlying clinics transmitting to a parent center such as EMR; DSS, Telemedicine, etc<br>• Implement an Informatics Service Line<br>• Develop a clinical and administrative information system that integrates information across sites and settings with easy access<br>• Develop a telematics program (telemedicine, teleradiology, teleimaging, telenuclear medicine, and telepathology)<br>• Educate users of Computerized Patient Records--beginning with primary care and mental health clinicians for implementation<br>• Develop management information systems to support management |
| ***Communication*** | • Continue implementation of network SEAT and redevelop the MAC on a state basis<br>• Communicate service line mission, vision, values, performance measures and expected outcomes with staff, patients and key stakeholders<br>• Implement a Network Stakeholder Relations Council by including stakeholders on teams, councils, and committees<br>• Implement local teams and councils, through facility public affairs officers, with local stakeholder groups<br>• Develop a network database to include group characteristics and concerns for identifying key stakeholders in all geographic areas within the network<br>• Insure that the messages going to external stakeholders are consistent and at the level of understanding of those stakeholders<br>• Enlist as many VHA employees as possible to reach as many external stakeholders as possible<br>• Anticipate when planned changes are likely to affect employees in ways they will perceive to be negative, mitigate the negative aspects as much as possible, and make sure external stakeholders are aware of the planned changes and actions taken on behalf of employees |

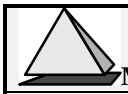
| | |
|---|---|
| ***Education*** | • Establish education centers for ongoing education in high priority areas<br>• Develop an affiliation council and complete report of recommendations on germane affiliate issues<br>• Determine primary care education needs within the service lines and each site<br>• Establish an Education Service Line for network wide education<br>• Develop and implement programs for coping skills; job counseling cross training and performance measures<br>• Educate clinicians regarding early warning signs and incorporating preventive health measures into primary care (i.e., early foot screening); increasing interdisciplinary involvement in the provision of temporary prostheses |
| ***Research*** | • The Research Service Line will explore mechanisms for increasing research funding and assure that all network facilities have or are part of non-profit research corporations<br>• Establish a Research Service Line with an Executive Director and operational budget<br>• Recruit and retain high quality investigators through a network career development program<br>• Review research management activities to improve efficiency and effectiveness of research operations<br>• Develop mental health research through federal, VHA, state and other sources |
| ***Sharing Agreements*** | • Implement Mental Health Service Line strategy that includes partnerships with community resources including half way houses and residential care centers |
| ***Contracting Services*** | • Determine how contracting services to community providers will attain efficiencies<br>• Contract for CBOC services as necessary and cost efficient<br>• Complete implementation planning for A&MM procurement consolidation into a Network Acquisition Center and other business office consolidations; negotiate consolidated contracts in '98; and begin transition to Network Acquisition Center and business office<br>• Blind rehabilitation program plans will use CARF standards allowing the possibility of contract services and sharing agreements with those institutions that are CARF certified |

| | |
|---|---|
| ***Facility and/or Service Consolidations*** | • Implement contract for consolidated transcription services<br>• The Acquisition Service Center will begin centralized contracting in FY98 and will implement full service acquisition activities<br>• Biomedical services consolidation will be reviewed by the network's Acquisition Service Center<br>• Augusta and Dublin will market their wheelchair repair services within the network and participation would depend upon cost of services<br>• Complete phase out of dental laboratories in the network<br>• Implement centralized responsibility for network OWCP position<br>• Implement integration of Montgomery and Tuskegee VAMCs:<br>⇒ Complete hiring of key management staff (clinical and administrative)<br>⇒ Produce concrete detailed implementation plans for integration by function<br>⇒ Submit plans to Congress (with 60 days for review) and, if the plans are satisfactory, there will be a 45 day waiting period until implementation of the integration |
| ***Emergency Preparedness*** | • Implement emergency response plan for the network (the plan provides specific guidance to the network facilities for meeting emergency preparedness responsibilities) |

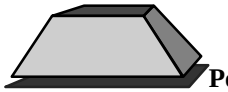

## NETWORK STRATEGIC PLAN SUMMARY

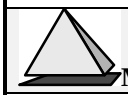
**Mission Goal:** Continue the Implementation of Service Lines

| Operating Strategies | Performance Goals |
|---|---|
| **Use Best Practices of Managed Care** | • Ensure appropriate productivity of primary care providers by establishing and implementing standardized patient panel size<br>• Establish a network-wide monitoring system for primary care<br>• Develop approach for consolidating primary care/mental health into an integrated primary care program<br>• Implement case/care management as the central element of interdisciplinary patient care<br>• Create a pilot rural health initiative that identifies needs in the rural frail elderly and intervenes with a case management model to fill gaps in their care |
| **Manage the Allocation of Resource** | • Improve network-wide, the ability for medical center, service line and network management to practice comprehensive capital asset management<br>• Develop budget-tracking system for Primary Care Service Line by implementing shadow budget |

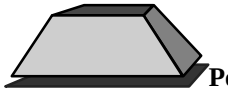


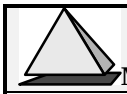
**Mission Goal:** Improve Geographic Access to Primary Care

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Shift from Inpatient to Outpatient Care** | • Develop a marketing plan for core and specialty services to include outreach to specialty populations<br>• Continue implementation of community based outpatient clinics<br>• Provide mental health core services at all CBOCs including on-site telemedicine services for special emphasis populations at limited sites |
| **Manage the Allocation of Resources** | • Perform in-depth study of existing local primary care programs within the Primary Care Service Line to improve process efficiency and customer service<br>• Decrease Mental Health Service Line annual costs two percent/year per unique user through '02<br>• Allocate scarce capital resources made available to the network from the non-recurring maintenance (NRM), minor, and major construction appropriations |

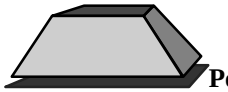


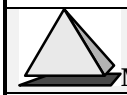
**Mission Goal:** Upgrade Informatics

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Enhance Information Systems** | • Improve network-wide, timely access to and interaction with clinical information for all that need it utilizing the computerized patient records system and telematics<br>• Expand digitization and transmission of radiological studies. Teleradiology will permit outlying clinics to transmit images to a parent medical center, thereby providing real-time rather than *post facto* interpretations, as well as introduce the potential to share radiology subspecialists.<br>• Establish uniform reporting requirements and definitions for purposes of uniform information sharing and management support<br>• Develop clinical decision tools (provider profiling and repository databases) and provide access to knowledge resources for care providers<br>• Create an electronic environment to facilitate the dissemination of information network-wide including documents, images, video and voice |

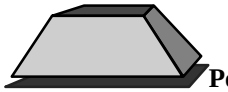


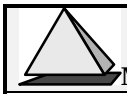
**Mission Goal:** Implement Service Consolidations

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Manage the Allocation of Resources** | • Through a consolidated reference laboratory contract, a 10 percent savings ($100 thousand annually) should be obtainable, with 20-25 percent ($200 - $250 thousand annually) set as a goal<br>• Standardization of glucose meters throughout the network to include coordination of systems for both inpatient and outpatient should result in significant cost savings in excess of $500 thousand annually with concomitant improvement in the quality of patient care<br>• Centralization of PCR assays<br>• Complete establishment of an Acquisition Service Center |



**Mission Goal:** Implement a Network Education System

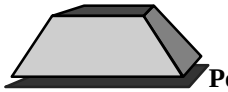
|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Link Education to Patient Care and be a Learning Organization** | • Determine programmatic needs, priorities; develop needs assessment tool for each subgroup<br>• Operationalize each component of service line to provide necessary network education activities to meet education goal of 40 hours per employee and needed training within the network<br>• Establish a Network Advisory Council, a sub-council of Deans, and a plan for education to coordinate educational resources, help bring about organizational and cultural change, and assist in retraining efforts<br>• Utilize the Career Training and Assistance Program (CTAP) and network education resources to retrain employees shifted to new jobs or displaced due to the consolidation or reductions<br>• Provide a mechanism for educating stakeholders, communicating research activities and facilitating collaboration among VISN 7 researchers |



**Mission Goal:** Focus Research Activities

**Operating Strategies**

**Link Education and Research with Patient Care**



**Performance Goals**

- Establish a Biomedical Research Service Line with an Executive Director and operational budget. The service line will fund academic needs for education and research activities separate from clinical care. This is essential in order to preserve the education and research missions
- The Atlanta Network has planned a Biomedical Research Service Line with the mission of improving the health of veterans and community through discovery and application of science. The intent is to foster the growth and vitality of research by integrating research activities within the network

## 1997 SELECTED ACCOMPLISHMENTS

- Enrolled veterans into either a Primary Care or Mental Health Service Line with a care manager/team/gatekeeper to direct care
- Northeast Program Evaluation Center data shows significant mental health program improvements
- Completed a contract for a CBOC in Dothan, AL
- Headquarters approval and submission to Congress of four additional CBOCs in Albany, GA; Macon, GA; Florence, SC; and Myrtle Beach, SC
- The submission to headquarters of an additional CBOC proposal for a CBOC in northeast Georgia
- Collocation of a primary care clinic at the Atlanta Readjustment Counseling Center to provide better access to veterans in midtown, downtown, and south Atlanta
- Established a network Infrastructure Management Service Line that planned and implemented capital initiatives based on network goals and actions
- Implemented an Information Technology Service Line which accomplished the following in '97:
  - ⇒ Implemented Microsoft Exchange across the network within the national system
  - ⇒ Planned and implemented the Telecommunications Infrastructure Project (TIP) - all TIP funds received have been obligated
  - ⇒ Established a DSS Council to accelerate implementation of DSS
  - ⇒ Established timelines and a network plan to implement the Computerized Patient Record System (CPRS) network-wide (VAMC Tuscaloosa being first in the nation to implement CPRS)
  - ⇒ Installation of a network-wide video conferencing system
- Established a Diagnostic Medicine Service Line which brought about efficiencies and quality improvement particularly in the areas of laboratory tests and high technology equipment
- Established an Extended Care Service Line which produced a strategic plan and received a grant to determine the placement needs of the frail rural elderly
- Maintained and improved programs for veterans with special disabilities
- Began the integration of the Montgomery and Tuskegee VA medical centers into the central Alabama Veterans Health Care System
- Began establishment of a Network Acquisition Center
- Accomplished a major shift from inpatient to outpatient care as evidenced by large reductions in bed days of care and large increases in outpatient visits
- All network medical centers, except one, have submitted reorganization plans to Network Director. All submitted have been approved. All include service lines in their organizational charts.
- Accomplished all planned NRM projects
- Accomplished all planned minor construction projects.
- Funded one minor construction project to correct privacy deficiencies at Birmingham
- Accomplished all planned high cost equipment procurements

***Information as of December 12, 1997. The financial and workload information presented in this package is currently under review for use in budget justifications submitted to Congress.***

**BUDGETARY DATA SET (VISN 7)** **Table B-1**

| | 1997 Base | 1998 Tactical | 1999 Strategic | 2000 Strategic | 2001 Target | 2002 Target | 2003 |
|---|---|---|---|---|---|---|---|
| **1. Financial ($'s in thousands):** | | | | | | | |
| a. Medical Care, Sources of Funding: | | | | | | | |
| VERA Allocation for Medical Care | $814,630 | $845,171 | $867,867 | $875,043 | $875,043 | $875,043 | |
| MCCR Collection [See Note] | | $34,494 | $38,066 | $42,510 | $46,671 | $51,231 | |
| Medicare Reimbursement | | $0 | $0 | $10,000 | $20,000 | $43,000 | |
| Tricare Collection | | $100 | $200 | $400 | $2,000 | $3,000 | |
| Other Sharing/Reimbursements | | | | | | | |
| Planned Unobligated Balances | | | | | | | |
| **Total = Allocation + Revenues** | $814,630 | $879,765 | $906,133 | $927,953 | $943,714 | $972,274 | $0 |
| b. Percent Revenues to Allocation + Revenues | 0.00% | 3.93% | 4.22% | 5.70% | 7.28% | 10.00% | |
| c. Distribution of Funding by selected activities: | | | | | | | |
| Acute Hospital Care | $195,503 | $186,546 | $174,075 | $159,277 | | | |
| Outpatient Care | $260,306 | $293,226 | $324,294 | $353,245 | | | |
| Long-Term Care | $67,902 | $74,760 | $82,482 | $88,457 | | | |
| Total | $523,711 | $554,532 | $580,851 | $600,979 | | | |
| **2. Federal Employment:** | | | | | | | |
| Average Employment (FTE), Total | 10,637 | 10,600 | 10,500 | 10,400 | | | |
| **3. Unique Patient Users (PRPs): [Unduplicated at the National Level]** | | | | | | | |
| a. Total Unique Patient Users (PRPs) | 168,521 | 180,566 | 187,474 | 191,859 | 195,302 | 202,507 | |
| Percent Increase/Decrease from 1997 Base | | 7.15% | 11.25% | 13.85% | 15.89% | 20.17% | -100.00% |
| b. Distribution of PRPs by Eligibility Category: | | | | | | | |
| Category A | 145,467 | 155,865 | 161,828 | 165,613 | | | |
| Category C | 5,612 | 6,013 | 6,243 | 6,389 | | | |
| Non-Veteran Users | 17,442 | 18,688 | 19,403 | 19,857 | | | |
| Total | 168,521 | 180,566 | 187,474 | 191,859 | | | |
| c. Distribution of PRPs by VERA Patient Groups: | | | | | | | |
| Special Care Unique Patient Users | 7,583 | 8,125 | 8,436 | 8,634 | | | |
| Basic Care Unique Patient Users | 160,938 | 172,441 | 179,038 | 183,225 | | | |
| Total | 168,521 | 180,566 | 187,474 | 191,859 | | | |
| **4. Workload Episodes:** | | | | | | | |
| a. Outpatient Visits (Staff & Fee) | 1,424,522 | 1,526,339 | 1,584,733 | 1,621,800 | | | |
| b. Acute Hospital Care: | | | | | | | |
| Acute Hospital Beds | 1,166 | 750 | 710 | 632 | | | |
| Acute Hospital ADC | 604 | 593 | 567 | 537 | | | |
| Acute Inpatients Treated | 35,881 | 34,601 | 32,332 | 29,780 | | | |
| c. Long-Term Care: | | | | | | | |
| Long-Term Beds | 3,169 | 3,169 | 3,171 | 3,244 | | | |
| Long-Term ADC | 2,459 | 2,609 | 2,695 | 2,758 | | | |
| Long-Term Inpatients Treated | 5,513 | 5,849 | 6,042 | 6,182 | | | |
| **5. Number of Facilities:** | | | | | | | |
| VA Hospitals | 9 | 8 | 8 | 8 | | | |
| VA Nursing Home Care Units | 6 | 7 | 7 | 7 | | | |
| VA Domiciliaries | 2 | 2 | 2 | 2 | | | |
| Outpatient Clinics: | | | | | | | |
| Hospital Based, Independent & Mobile | 10 | 10 | 10 | 10 | | | |
| CBOCs, CBCs, Satellite & Outreach | 9 | 15 | 20 | 22 | | | |
| **6. Financial Measures (Medical Care):** | | | | | | | |
| a. Obligations Per Unique User Analysis (30% network goal): | | | | | | | |
| Obligations Per Unique User | $4,834 | $4,872 | $4,833 | $4,837 | $4,832 | $4,801 | |
| Percent Change from 1997 Base | | 0.79% | -0.02% | 0.06% | -0.04% | -0.68% | |
| Assumed Portion Current Services | | 3.75% | 7.63% | 11.63% | 15.45% | 19.92% | 24.28% |
| Percent Change Net of Current Services | | -2.96% | -7.65% | -11.57% | -15.49% | -20.60% | |
| b. % Change in Unique Patient Users from 1997 base, from line 2a. above (20% network goal) | | 7.15% | 11.25% | 13.85% | 15.89% | 20.17% | -100.00% |
| c. % Revenues to Allocation + Revenues, from line 1b. above (10% network goal) | 0.00% | 3.93% | 4.22% | 5.70% | 7.28% | 10.00% | |
| d. % of Acute Hosp.$s to Tot.of Acute $s + OP $s | 42.89% | 38.88% | 34.93% | 31.08% | | | |
| e. Outpatient Visits Per Unique User | 8.45 | 8.45 | 8.45 | 8.45 | | | |
| f. Med. Care Capital Obligations Per Unique User | $333 | $218 | $213 | $212 | | | |

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# VA FLORIDA/PUERTO RICO SUNSHINE HEALTHCARE NETWORK (NETWORK 8)

PLAN SUMMARY

## VISN OVERVIEW

VISN 8, the Florida/Puerto Rico Sunshine Healthcare Network, includes facilities located in Florida, South Georgia, Puerto Rico, and the U.S. Virgin Islands. The estimated '97 veteran population is 1,753,300 with 42.6 percent of veterans in the network age 65 years or older. The network is comprised of seven medical centers, 7 nursing homes, and 17 multi-specialty, community-based outpatient clinics. State Veteran Homes are located in Lake City, FL; Puerto Rico; and Daytona Beach, FL. An additional State Veteran Home will be established in Pasco County, FL in FY99. There are also 14 Vet Centers spread throughout the network.

## PLAN HIGHLIGHTS

| | |
|---|---|
| ***Quality*** | • Define VISN's case management concept and implement the most cost-effective model<br>• Establish criteria for determining successful implementation of clinical guidelines<br>• Develop method for linking laboratory, radiology, and pharmacy costs to use of clinical guidelines and reduce unit costs while maintaining quality<br>• Develop shared decision-making protocols in consideration of patients' preferences<br>• Conduct utilization management activities for all levels of care by 2000 |

| | |
|---|---|
| ***Performance Measurement System*** | • Increase sufficiency rates for C&P exams by promoting dialogue with VBA staff and case-by-case problem solving<br>• Provide training for C &P and Gulf War examiners<br>• Develop an enrollment process for the network<br>• Increase enrollment of women veterans by 20 percent annually through FY 2000<br>• Develop information method to track customer satisfaction data<br>• Provide 100 percent of psychiatric patients Global Assessment of Functioning (GAF) score.<br>• Apply Addition Severity Index (ASI) at both enrollment and at 90 days post treatment<br>• Increase third party collections two percent annually.<br>• Increase total unique patients served by 29 percent by FY 2000<br>• Reduce acute bed days of care to 1,000 BDOC per 1,000 unique users by FY 2000<br>• Enroll 92 percent of ambulatory care patients in primary care by 2000<br>• Improve scores on customer service standards relative to those received in the 1997 survey<br>• Increase the number of PTSD veterans served per FTEE |
| ***Customer Service*** | • Foster commitment/support for a patient-centered culture via communication mechanisms<br>• Develop education programs for employees and a recognition system to support a customer service environment<br>• Replace/expand SOPC space at Port Richey, Ft. Myers, Ponce, Jacksonville and Oakland Park |
| ***Primary Care/Case Management*** | • Designate case managers for select patient populations (e.g., terminally ill)<br>• Complete construction of new VA Clinic in Brevard County in '98<br>• Expand mission at the Orlando Clinic by '00 to include geropsychiatric nursing home and domiciliary<br>• Establish a special treatment program at Bay Pines for sexual trauma victims<br>• Develop VISN-wide protocols for sharing decision-making with patients (e.g., therapeutic choices for treating prostate cancer, mammography for women age 40-49)<br>• Expand outpatient capacity by renovating existing inpatient space at Lake City, Miami, Tampa, West Palm Beach, and Bay Pines |
| ***Special Emphasis Programs and Six Disabling Conditions*** | • Ensure all psychiatric patients receive Global Assessment of Functioning (GAF) score to identify seriously mentally ill veterans<br>• Finalize agreement for referral of selected seriously mentally ill patients to long-term care program at VAMC Biloxi (VISN 16)<br>• Support continuance of two existing intensive psychiatric community care (IPCC) programs (Miami, Gainesville) and assess need to establish IPCC programs in central Florida and San Juan<br>• Develop PTSD standards of care, and expand educational offerings in VISN for assessment and treatment of PTSD<br>• Address provision of substance abuse services to special populations, e.g., geriatric, minority, and women veterans<br>• Develop tools for primary care providers so more veterans are identified and referred for substance abuse treatment |

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| | • Promote use of primary care and case management for the homeless<br>• Conduct a needs assessment of VISN homeless programs and identify unmet needs<br>• Collect baseline data on the number of veterans in non-funded homeless programs receiving an assessment for veterans benefits<br>• Develop VISN-wide contract(s) for home health services<br>• Complete VISN-wide implementation of long term care minimum data set for measuring extended care outcomes<br>• Reduce waiting times for orthopedics and optometry clinics to facilitate issuance of prosthetic devices<br>• Referral protocols will specify medical conditions to be treated by SCI/D clinics/primary care teams, and standard operating procedures for patient referral/transport<br>• Implement recently designed VISN 8 encounter form to collect uniform Gulf War veterans SEAT data |
| ***Community Based Outpatient Clinics (CBOCs)*** | • Ocala, FL; Ft. Pierce; Cecil Field; Brooksville;N Pinellas County; S. St. Petersburg; SW Broward County; S. Hillsborogh County; Valdosta, GA ('98)<br>• Lakeland, FL; Leesburg; Key Largo; Manatee County; Port Charlotte; S. Palm Beach County; Arecibo, PR; Fajardo/Ceiba ('99)<br>• Naples, FL; Arcadia; Citrus County; East Pasco County; Okeechobee County; SE Broward County; Lake Wales/Kissimmee ('00)<br>• Martin County, FL; Putnam County; NW Broward County ('01) |
| ***Community Based Care Initiatives*** | • Outpatient clinic lease expansions are scheduled at Ponce ('98), Ft. Myers ('98) and Port Richey ('99)<br>• Fully implement telemedicine VISN-wide<br>• Explore alternative community funding for homeless programs |
| ***Service Lines*** | • Identify and implement clinical service lines, as appropriate, to expand and improve the delivery of care across sites in the integrated Veterans Health System of North Florida/South Georgia |
| ***Improving Clinical and Administrative Information Systems*** | • Establish linkage with Decision Support System (DSS) for monitoring extended care resource utilization<br>• Enhance telecommunications infrastructure (including audio, video, and data transfer) within and between facilities<br>• Assess and correct Year 2000 impacts on operations and patient care activities<br>• Increase patient satisfaction through access to information (directly and in support of medical care delivered)<br>• Finish implementing DSS at Miami, West Palm Beach, and San Juan<br>• Develop DSS VISN-wide policy and standard clinical indicators through the establishment of a continuous quality improvement (CQI) team<br>• Implement second phase of Automated Medical Information Exchange (AMIE II) project to reduce the amount of time needed to determine veteran eligibility and process a claim for benefits |

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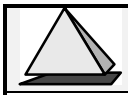
| ***Communication*** | • Ensure that effective and timely communications occur at all levels of the organization to foster a patient-centered culture<br>• Have a televideo conferencing system accessible throughout the VISN at start of '98 |
| ***Education*** | • Provide advanced training (master's level) for advanced practice nurses to expand utilization in primary care delivery<br>• Analyze and make recommendations for the consolidation of training programs, especially in the more highly specialized areas such as cardio-thoracic surgery |
| ***Research*** | • Conduct pilot studies to select nurse-sensitive outcome indicators for rehabilitation to identify innovations in nursing care delivery<br>• Identify valid, reliable, practical measurement tools related to nurse staffing, care delivery, clinical outcomes, patient satisfaction, and cost across the rehabilitation care continuum |
| ***Sharing Agreements*** | • Increase TriCare revenue collections to $2 million by 2000<br>• Consolidate facility VA/DOD sharing agreements into a single VISN agreement with Naval Office of Medical/Dental Affairs<br>• Pursue consolidation of other DOD contracts, CHAMPVA, and non-federal contracts |
| ***Contracting Services*** | • Establish a fee-basis policy to assure access to qualified clinicians in private sector for veterans not accessible to SCI/D care<br>• Accelerate VISN standardization of projects, and centralize contract data<br>• Consolidate purchase of utilities (gas and electricity) VISN-wide<br>• Develop partnerships with other VISNs to consolidate common contracts<br>• Assure that educational opportunities are provided to contracting staff<br>• Develop VISN-wide contract(s) for home health services<br>• Initiate a pilot in east central Florida to evaluate cost effectiveness of contracting with private sector hospitals |
| ***Managing Human Resources*** | • Initiate career development directed to those who have a high probability of transitioning into new jobs<br>• Provide leadership training to all levels of supervision VISN-wide, including potential supervisors |
| ***Facility and/or Service Consolidations*** | • Integrate services at San Juan in FY98<br>• Create a "Veterans Health System of North Florida/South Georgia" and recruit System Director during FY98 |
| ***Emergency Preparedness*** | • Continue implementation of the Incident Command System VISN-wide<br>• Continue to improve readiness through closer integration with local communities, especially in supporting development of Metropolitan Medical Strike Teams (MMSTs) under Nunn-Lugar-Domenici legislation |

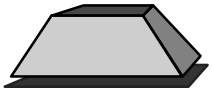

## NETWORK STRATEGIC PLAN SUMMARY



**Mission Goal**: Increase Health Care Users

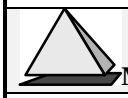
**Operating Strategies**

**Improve Access to Care**



**Performance Goals**

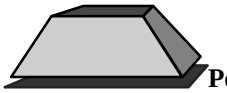
- **'00:** Increase number of community-based outpatient clinics (CBOCs) by +24
- **'00:** Increase number of veterans receiving acute rehabilitation by serving greater portion of those with new injuries, or with other spinal cord disorders
- **'00:** Expand mission at the Orlando clinic to include geropsychiatric nursing home and domiciliary care



**Mission Goal:** Improve Access for Women

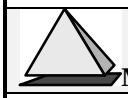
**Operating Strategies**

**Improve Care for Women Veterans**



**Performance Goals**

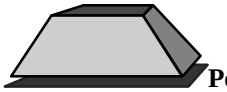
- **'00:** Increase enrollment of women by 20 percent a year
- **'00:** Develop VISN-wide protocol for shared decision-making regarding mammography for ages 40-49
- **'00:** Establish regional referral center for treatment of sexual trauma



**Mission Goal:** Decrease Cost per Patient

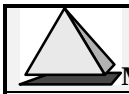
**Operating Strategies**

**Shift Focus from Inpatient to Outpatient Care**

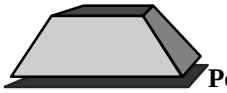


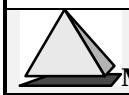
**Performance Goals**

- **'98:** Complete ambulatory care addition at Puerto Rico
- **'99:** Complete ambulatory care addition at Gainesville and new specialty clinic in Brevard County
- **'00:** Reduce acute bed days of care to 1,000/1,000 unique users

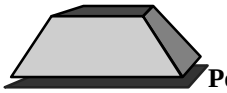


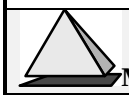
**Mission Goal:** Enhance Primary Care Program

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Increase Primary Care Standardization** | **'00:** Assure provision of primary care at Vet Centers<br>**'00:** Capture preventive health data at primary care access points and display electronically for practitioners<br>**'00:** Increase utilization of physician extenders and nurse managed care |

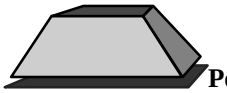


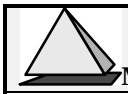
**Mission Goal:** Comprehensive Quality & Organizational Accountability Framework

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Establish Effective Network-wide Utilization Management (UM) Program for Controlling Resources While Maintaining Quality** | **'99:** Reduce lab costs/unique by $35, radiology costs by $36, and pharmaceutical costs by $44<br>**'00**: Ensure that patients are transferred to appropriate level of care within 24 hours of change in status<br>**'00:** Define various levels within continuum of care and develop plans for utilizing all levels of continuum<br>**'00:** Reduce average acute bed days of care to 1,000 BDOC/ 1,000 unique users |

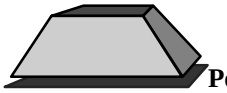


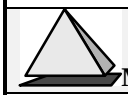
**Mission Goal:** Improve Customer Satisfaction

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Improve Customer Service Standards** | **'99:** Have tele-video conferencing system accessible VISN-wide in '98, with full implementation of telemedicine<br>**'00:** Develop VISN-wide educational programs for all employees on customer service<br>**'00:** Continue increase in sufficiency rates for C&P exams by promoting dialogue with VBA staff and case-by-case problem solving |
| **Develop Patient Education Programs** | **'00:** Provide education to homeless veterans on eligibility reform and related enrollment process<br>**'00:** Disseminate best practice models among facilities to provide comparable-quality education services, and obtain HSR&D funding to implement evidence-based chronic disease self-management program |



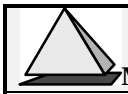
**Mission Goal:** Strengthen Stakeholder Relationships

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Increase External Stakeholder Collaboration** | **'98:** Conduct open congressional forums on a regular basis |
| **Communicating With Stakeholders** | **'00:** Put a customer service column in each facility newsletter<br>**'00:** Improve communication with congressional liaisons and veterans service organizations<br>**'00:** Develop a "home page" for veterans to use, with access to the Intranet and Internet |

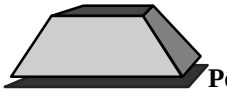


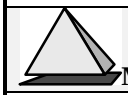
**Mission Goal:** Improve Veterans' Healthcare Delivery

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Enhance Intra-VA Collaboration** | **'98:** Second phase of Automated Medical Information Exchange (AMIE II) project will reduce amount of time needed to determine veteran eligibility and process a claim for benefits<br>**'00:** To facilitate seamless transition from active military to veteran status, VISN 8 is working with VARO representatives to explore establishment of sharing agreement with DOD to provide C&P exams at point of military discharge |

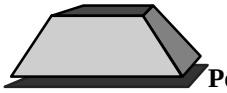


**Mission Goal:** Be a Leader in Research and Education

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Promote Research Related to Healthcare of Veterans** | **'00:** Increase total research funding by 10 percent across VISN<br>**'00:** Conduct a VISN 8 research study to track long-term health status of Gulf War veterans |
| **Develop Provider Education With a Patient Focus** | **'98:** Provide master's level education for advanced practice nurses via a long distance learning program, piloted with St. Louis University<br>**'00:** Minimize the negative impact on patient care and affiliations that the reduction in specialty residency positions has at some medical centers in the VISN<br>**'00:** Increase research activities in areas impacted by changes in the healthcare delivery system<br>**'00:** Develop a generic Patient Health Education Newsletter for VISN veterans |



**Mission Goal:** Be an Employer of Choice

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Establish Career Development Services** | **'00:** Ensure a commitment to employee education and training by each leader in the network<br>**'00:** Create a "change management" program to focus on the dynamic work environment and how employees can cope, and initiate career development directed to those who have a high probability of transitioning into new jobs |

## 1997 SELECTED ACCOMPLISHMENTS

- Explored various enrollment strategies and budget/capacity issues
- Developed a general veterans benefits package and draft "managed care" brochure for veterans, and formally requested to be a pilot VISN for "enrollment"
- Explored network-wide approach to implementing eligibility rules and enrolling veterans into managed care programs
- Identified outreach strategies to increase Category A veteran users, increasing Category A users by 13,338 over '96 levels
- Developed system for "uniform data capture" of women veterans health program elements
- Developed a draft business/marketing plan to reach more women veterans
- Conducted a mini-residency program for newly appointed women veterans coordinators
- Based on survey done at all VISN 8 facilities, proposed establishment of referral center for treatment of sexual trauma at VAMC Bay Pines
- Reduced hospital operating beds by 509 (20 percent) to 1,988 beds, and acute bed days of care (BDOC)/1,000 unique users by 30 percent to 1,435 BDOC/1,000 uniques
- Increased unique users by 9,413 over '96 levels, to 249,507 users served
- Increased ambulatory surgery (on HCFA list) from 38 percent in '96 to 71 percent in '97
- Developed VISN encounter form to electronically document patients receiving chronic disease and preventive health services
- Designed a "healthy living" brochure to meet the education and counseling needs of primary care patients
- Initiated a long distance pilot learning program with St. Louis University to provide master's level education for advanced practice nurses
- Developed and implemented 10 clinical guidelines
- Created generic encounter form for mental health services
- Developed standardized PTSD intake-screening instrument for hospital and outpatient settings as well as Vet Centers
- Developed VISN-level "Utilization Management (UM) Report Card" of indicators on Intranet
- Conducted facility-specific UM program assessment
- Assured implementation of pre-admission screening
- Assessed implementation status of telephone care
- Identified critical linkages for addressing UM activities, i.e., primary care, extended care, and Chiefs of Staff
- Identified barriers to compliance with InterQual criteria
- Developed an implementation plan to institute clinical guidelines VISN-wide
- Developed a customer service plan with actions, responsible individuals, time frames, estimated costs, and performance measures
- Compiled resource guide of available homeless programs in VISN 8 and conducted program "Service Days for Homeless Veterans" at four sites
- Defined a full continuum of services available for extended care/geriatric patients, including home health
- Completed a cost comparison study of various extended care services
- Developed a draft extended care benefits package
- Secured Robert Wood Johnson Foundation grant for participating in Institute for Health Improvement's training program for improving "end-of-life" care
- Initiated a prosthetics formulary to eliminate costly duplications where appropriate, with 41 items identified for VISN-wide standardization over the next 3 years

- Established a Service Evaluation & Action Team (SEAT) for Gulf War veterans to rapidly resolve and monitor trends on customer satisfaction, and serve as a forum for public exchange of information
- Developed an executive information system, incorporating outcomes-based performance, workload, clinical guidelines, and cost measures into automated reporting system
- Established a VISN Intranet Web Page as a clearinghouse for VISN information, including strategic plans and work group plans
- Published VISN 8 "Rise & Shine" Newsletter quarterly to share "best practices" among facilities and to effectively communicate to stakeholders
- Provided two satellite video broadcasts featuring the Network Director
- Conducted a joint session of the Management Assistance Council (MAC) and the VISN's ELC; discussion included the proposed Gainesville/Lake City integration
- Maintained communication with all stakeholders during integration planning phase via publication of a weekly newsletter
- Network Director conducted "Town Hall" meetings at each facility in the VISN, and a Congressional forum
- Management Assistance Council (MAC) members actively participated on Network work groups
- The MAC helped resolve issues such as standardized issuance and acceptance of VA patient data/ ID cards, completion of disability forms by VA physicians for parking
- Health Systems Research & Development (HSR&D) Grant Advisory Committee is currently monitoring a two-year funded program on innovations in nursing care delivery across the rehabilitation care continuum
- A research study is underway to identify an implementation strategy to overcome potential resistance to successful utilization of advanced practice nursing in the primary care setting
- Completed an assessment of the employee education and retraining needs
- Provided education and training to VISN 8 providers on implementation of 14 clinical guidelines
- Defined VISN criteria for standardizing "best practice" of patient health education
- Conducted a VISN survey to assess the status of patient health education
- Identified a model for veterans with multiple chronic diseases
- Increased sufficiency rates for Compensation and Pension exams to 99.9 percent
- AMIE II builds on successful collaboration between VISN 8 office, VAMCs and the St. Petersburg VA Regional Office to use databases more effectively

***Information as of December 12, 1997. The financial and workload information presented in this package is currently under review for use in budget justifications submitted to Congress.***

**BUDGETARY DATA SET (VISN 8)** **Table B-1**

| | 1997 Base | 1998 Tactical | 1999 Strategic | 2000 Strategic | 2001 Target | 2002 Target | 2003 Target |
|---|---|---|---|---|---|---|---|
| **1. Financial ($'s in thousands):** | | | | | | | |
| a. Medical Care, Sources of Funding: | | | | | | | |
| VERA Allocation for Medical Care | $1,018,139 | $1,055,758 | $1,067,123 | $1,067,123 | $1,067,123 | $1,067,123 | $1,067,123 |
| MCCR Collection [See Note] | $0 | $37,000 | $46,250 | $55,500 | $66,534 | $79,841 | $79,920 |
| Medicare Reimbursement | $0 | $500 | $1,500 | $8,000 | $10,000 | $15,000 | $15,000 |
| Tricare Collection | $174 | $500 | $1,000 | $2,000 | $3,000 | $4,000 | $4,000 |
| Other Sharing/Reimbursements | $3,970 | $6,000 | $9,000 | $12,000 | $16,000 | $19,700 | $19,700 |
| Planned Unobligated Balances | $0 | ($4,623) | ($4,621) | ($55) | $0 | $0 | $0 |
| **Total = Allocation + Revenues** | $1,022,283 | $1,095,135 | $1,120,252 | $1,144,568 | $1,162,657 | $1,185,664 | $1,185,743 |
| b. Percent Revenues to Allocation + Revenues | 0.41% | 4.02% | 5.16% | 6.77% | 8.22% | 10.00% | 10.00% |
| c. Distribution of Funding by selected activities: | | | | | | | |
| Acute Hospital Care | $351,463 | $362,920 | $337,462 | $343,387 | | | |
| Outpatient Care | $432,891 | $483,894 | $506,193 | $515,080 | | | |
| Long-Term Care | $94,696 | $98,484 | $105,378 | $114,862 | | | |
| Total | $879,050 | $945,298 | $949,033 | $973,329 | | | |
| **2. Federal Employment:** | | | | | | | |
| Average Employment (FTE), Total | 13,028 | 13,144 | 13,384 | 13,474 | | | |
| **3. Unique Patient Users (PRPs): [Unduplicated at the National Level]** | | | | | | | |
| a. Total Unique Patient Users (PRPs) | 235,918 | 248,893 | 261,869 | 278,383 | 293,718 | 304,500 | 304,500 |
| Percent Increase/Decrease from 1997 Base | | 5.50% | 11.00% | 18.00% | 24.50% | 29.07% | 29.07% |
| b. Distribution of PRPs by Eligibility Category: | | | | | | | |
| Category A | 205,248 | 216,537 | 227,826 | 242,193 | | | |
| Category C | 7,078 | 7,467 | 7,856 | 8,352 | | | |
| Non-Veteran Users | 23,592 | 24,889 | 26,187 | 27,838 | | | |
| Total | 235,918 | 248,893 | 261,869 | 278,383 | | | |
| c. Distribution of PRPs by VERA Patient Groups: | | | | | | | |
| Special Care Unique Patient Users | 9,906 | 10,210 | 10,494 | 10,830 | | | |
| Basic Care Unique Patient Users | 226,012 | 238,683 | 251,375 | 267,553 | | | |
| Total | 235,918 | 248,893 | 261,869 | 278,383 | | | |
| **4. Workload Episodes:** | | | | | | | |
| a. Outpatient Visits (Staff & Fee) | 2,447,800 | 2,582,514 | 2,717,153 | 2,888,502 | | | |
| b. Acute Hospital Care: | | | | | | | |
| Acute Hospital Beds | 1,361 | 1,180 | 1,104 | 1,045 | | | |
| Acute Hospital ADC | 904 | 839 | 796 | 762 | | | |
| Acute Inpatients Treated | 36,283 | 33,690 | 31,933 | 30,583 | | | |
| c. Long-Term Care: | | | | | | | |
| Long-Term Beds | 1,290 | 1,298 | 1,280 | 1,411 | | | |
| Long-Term ADC | 1,691 | 1,711 | 1,695 | 1,813 | | | |
| Long-Term Inpatients Treated | 4,517 | 4,570 | 4,527 | 4,843 | | | |
| **5. Number of Facilities:** | | | | | | | |
| VA Hospitals | 7 | 7 | 7 | 7 | | | |
| VA Nursing Home Care Units | 7 | 7 | 7 | 8 | | | |
| VA Domiciliaries | 1 | 1 | 1 | 2 | | | |
| Outpatient Clinics: | | | | | | | |
| Hospital Based, Independent & Mobile | 7 | 7 | 7 | 7 | | | |
| CBOCs, CBCs, Satellite & Outreach | 17 | 26 | 34 | 41 | | | |
| **6. Financial Measures (Medical Care):** | | | | | | | |
| a. Obligations Per Unique User Analysis (30% network goal): | | | | | | | |
| Obligations Per Unique User | $4,333 | $4,400 | $4,278 | $4,111 | $3,958 | $3,894 | $3,894 |
| Percent Change from 1997 Base | | 1.55% | -1.27% | -5.12% | -8.65% | -10.13% | -10.13% |
| Assumed Portion Current Services | | 3.75% | 7.63% | 11.63% | 15.45% | 19.92% | 24.28% |
| Percent Change Net of Current Services | | -2.20% | -8.90% | -16.75% | -24.10% | -30.05% | -34.41% |
| b. % Change in Unique Patient Users from 1997 base, from line 2a. above (20% network goal) | | 5.50% | 11.00% | 18.00% | 24.50% | 29.07% | 29.07% |
| c. % Revenues to Allocation + Revenues, from line 1b. above (10% network goal) | 0.41% | 4.02% | 5.16% | 6.77% | 8.22% | 10.00% | 10.00% |
| d. % of Acute Hosp.$s to Tot.of Acute $s + OP $s | 44.81% | 42.86% | 40.00% | 40.00% | | | |
| e. Outpatient Visits Per Unique User | 10.38 | 10.38 | 10.38 | 10.38 | | | |
| f. Med. Care Capital Obligations Per Unique User | $326 | $260 | $285 | $261 | | | |

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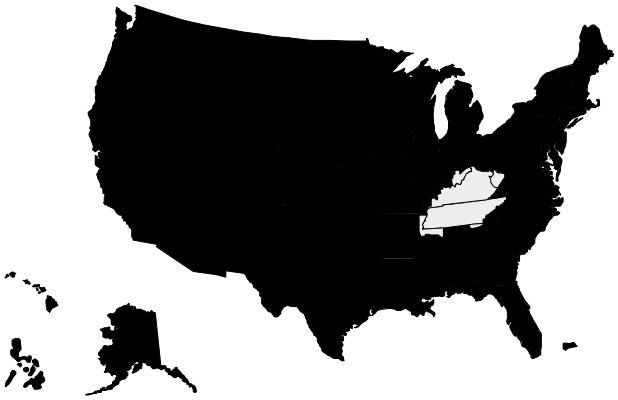
# MID SOUTH HEALTHCARE NETWORK (NETWORK 9)
PLAN SUMMARY

## VISN OVERVIEW



The Mid South Healthcare Network is comprised of seven medical centers. The geographic service delivery area includes portions of Kentucky, Tennessee, West Virginia, Mississippi, Virginia, Missouri, Georgia, Alabama, Indiana, Illinois, and Ohio. The estimated 1997 veteran population is 1,017,300 with over 170,000 individuals annually seeking care at one of the network facilities. Approximately 3 percent of the veteran population are women. The geographic area is over 500 miles east to west and 300 miles north to south. There are identified gaps throughout the population evident in the disproportionate market penetration.

## PLAN HIGHLIGHTS

| | |
|---|---|
| ***Quality*** | • Establish a minimum outcome data set to include length of stay by DRG, BDOC/1000, and number of re-admissions within 30 days<br>• Share best practices relating to beneficiary travel among medical centers to improve and standardize OWCP programs<br>• Form an interdisciplinary surgical advisory group at the network level to:<br>⇒ Develop a plan for identifying and improving surgical program efficiency and effectiveness benchmarks<br>⇒ Design a strategy to ensure surgical program workload is sufficient to maintain provider skills and high quality outcomes<br>⇒ Project to expand ambulatory surgery at Louisville will provide capacity to increase outpatient surgery workload<br>⇒ Develop inpatient centers of excellence for complex and challenging patients |

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| ***Performance Measurement System*** | • Continue to use guidelines promulgated by the National Center for Health Promotion, with computerized tracking of compliance fully implemented by '99<br>• Incorporate HEDIS measures into the Balanced Scorecard<br>• Develop a process for Network-wide population-based planning. This process may include the use of instruments such as SF-36, GAF, or FIM<br>• Compare and share performance indicators/measures between all network facilities, using the information to identify areas for improvement and promulgate best practices throughout the network<br>• Surpass the targets set forth in the annual VHA performance measures; continue placing performance measures into the performance plans of medical center directors, chiefs of staff and Associate Directors; continue performance measures relevant to the service chiefs and supervisors at the medical center level |
| ***Customer Service*** | • Conduct analyses within each Firm (an interdisciplinary group practice of physicians with appropriate mix of allied health professionals and support staff for individual medical center patient populations) to identify factors responsible for excessive waiting times<br>• Establish customer sensitivity as a cultural imperative for the Mid South Network<br>• Standardize products/services to improve current user satisfaction<br>• Provide telephone triage and telephone care services 24 hours a day |
| ***Primary Care/Case Management*** | • Establish Firms which incorporate as many functions as possible for maximum patient convenience; ensure responsibility and accountability for all health related services required by patients while assigned to the FIRM; incorporate all non-emergent ambulatory medical care, and coordination of specialty care<br>• Expand ambulatory surgery at Louisville to provide capacity to increase outpatient surgery workload<br>• Move toward interdisciplinary team-based care within Same Day Surgery and Procedures (SDP); extend effective working hours with staggered duty hours of staff<br>• Authorize physician extenders to treat and/or refer patients for care consistent with their scope of practice utilizing accepted clinical guidelines<br>• Develop a standardized case management model at each medical center; adopt large case management for high risk patients and episodic case management of inpatients<br>• Establish a Home Based Primary Care (HBPC) program at medical centers where feasible<br>• Convert inpatient space to outpatient usage, establishing primary care |

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| ***Special Emphasis Programs and Six Disabling Conditions*** | • Develop a standardized method to classify special care patients<br>• Designate a lead facility for each of the SEPs<br>• Implement FIRM-based case managers to utilize special treatment protocols for disease management when available for Special Emphasis Programs (SEPs)<br>• Each medical center and eight VA operated CBOCs will offer a range of mental health services while additional contract clinics may provide screening and limited intervention programs<br>• Develop a funding mechanism at the network level to financially support those programs which are significantly resource intensive beyond the usual capitation rate<br>• Long-term care efforts will continue to focus on providing care in the home with support through community contracts |
| ***Community Based Outpatient Clinics (CBOCs)*** | Locations — Fiscal Year<br>• Clarksville, TN — '98<br>• Charleston, WV — '98<br>• Frankfurt, KY — '98<br>• Northern Mississippi — '98<br>• Southern Indiana — '99<br>• Somerset, KY — Future<br>• Morehead/Grayson, KY — Future |
| ***Community Based Care Initiatives*** | • Establish partnerships with service organizations in their primary service area to assist in conducting health fairs for their constituents<br>• Implement 10 to 20 additional contract sites throughout the service area<br>• Utilize extended care contracts in the community to improve access for veterans and their families where feasible<br>• Implement preventive medicine screening clinics to increase access to VA health services, particularly in populated areas more than 30 miles from existing facilities<br>• Limited ambulatory surgery and mental health services will be established at all VA operated outpatient clinics<br>• Mental health services will be expanded towards community-based care |
| ***Service Lines*** | • None planned |
| ***Improving Clinical and Administrative Information Systems*** | • Require all future procurements of digital imaging equipment to be compatible with the Veterans Health Information Systems & Technology Architecture (VISTA)<br>• Utilize the existing data (KLF, PAID, FMS, COIN, CDR, CMR, PTF, DHCP, and local data options) to obtain clinical information, cost information, patient data, and provider-specific data as an interim until a Decision Support System is implemented. Develop specific goals and timeliness as established by the ELC for the implementation of the electronic medical record at each facility<br>• Establish automated database sharing with federal agencies who share interest in our veteran patients assuring patient confidentiality<br>• Provide Network and medical center level data validation on issues identified through KLF training<br>• Fully utilize the Decision Support System (DSS) to evaluate operational effectiveness during the current fiscal year<br>• Develop a shared information system through the Medical Informatics Committee |

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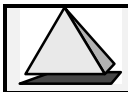
|---|---|
| ***Communication*** | • Develop local business advisory committees of selected business leaders to get their input and assistance on VA network programs impacting the community<br>• Establish a Network Marketing Council to manage marketing functions for the Mid South Veterans Healthcare Network<br>• Develop and implement a network-wide marketing campaign to achieve "brand recognition" of the Mid South Healthcare Network as an integrated healthcare delivery system<br>• Publish monthly newsletter to provide employees with current information, changes and direction<br>• Conduct periodic open "town meetings" |
| ***Education*** | • Expand current projects to develop and evaluate new and innovative methods of delivering primary care to patients with academic affiliates<br>• Utilize specialists to provide ongoing education to interdisciplinary primary care teams (FIRMS) and to provide consultation for the most difficult cases<br>• Promote continuity and resident involvement in primary care services<br>• Establish resident "continuity" clinics and assign panels of patients to residents for a minimum of ½ day per week for at least two years |
| ***Research*** | • Link education and research by enhancing medical school facility at Mt. Home, TN<br>• Provide network-wide training in research methodology to clinical staff interested in quality management techniques<br>• Coordinate network research activities |
| ***Sharing Agreements*** | • Initiate and promote a CHAMPVA program at each medical center including the marketing of women's health services<br>• Establish mechanism to gather data about military personnel/dependents<br>• Provide education to other agencies and community individuals, and charge for this training<br>• Identify the availability of assets at each facility suitable for lease to the private sector under the Enhanced Use Leasing process<br>• Establish mechanism for coordinating all sharing agreements with DOD, TriCare, and CHAMPVA<br>• Market excess capacity to DOD beneficiaries |
| ***Contracting Services*** | • Implement 10 to 20 additional community-based outpatient clinic sites throughout the service area<br>• Evaluate network-wide contract with a maintenance management organization for the maintenance of all Network medical, ADP, building services equipment, and office equipment, within three months<br>• Explore an energy savings performance contract for the audit of each facility's energy consumption<br>• Review options for purchasing electrical/utilities as a result of industry deregulation and other options now available<br>• Implement financial controls for sharing agreements with academic affiliates which ensure average charges for medical services do not exceed the appropriate Medicare reimbursement rate<br>• Ensure that proper business office practices such as billing, coding, and collecting are utilized to maximize revenue with DOD, sharing partners, CHAMPVA, and TriCare |

| | |
|---|---|
| ***Managing Human Resources*** | • Use results of the "One VA" employee survey to determine areas of strengths and weaknesses in terms of being an employer of choice<br>• Assemble a network task force to facilitate strategy development of findings from the "One VA" employee survey<br>• Link incentives and rewards for teamwork and innovation to contributions in achieving or improving medical center/service level performance priorities/measures |
| ***Facility and/or Service Consolidations*** | • Develop a process that includes multi-disciplinary and like service chiefs (all medical centers) to identify acceptable data sources and methodology for meaningful comparison of workload and efficiency of their services for the purpose of developing cost containment initiatives and potential consolidation/integrations and researching industry innovations<br>• Close approximately 250 acute care beds, as a result of improved efficiency, over the next five years<br>• Initiate a task force to study the consolidation of selected clinical support programs among more than one facility to reduce redundant efforts |


## NETWORK STRATEGIC PLAN SUMMARY



**Mission Goal:** Provide Excellence in Healthcare Value

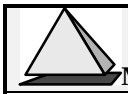
| Operating Strategies | Performance Goals |
|---|---|
| **Increase Primary Care Enrollment** | **'98:** Re-engineer primary and specialty care to allow physicians, nurses, and other health care providers to work as teams<br>**'99:** Market community-based clinics to eligible veterans<br>**'00:** Retain patient incident reporting and occurrence screening databases until final decisions about the VHA risk management program are made |
| **Enhance Information Systems** | **'98:** Improve automation and workflow through the full implementation of a graphical user interface (GUI) and a computerized patient record system (CPRS)<br>**'98:** Develop and implement the GUI system under the Network's Informatics Committee's scope of work and mission with emphasis on a planned approach, uniformity and consistency to ensure network compatibility and maximize efficiency |

**Mission Goal:** Provide Excellence in Education and Research

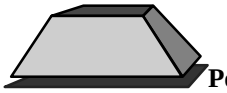
| Operating Strategies | Performance Goals |
|---|---|
| **Link Education and Research to Patient Care** | **'99:** Define VHA research in medical centers as a desirable activity for the network<br>**'99:** Coordinate network research activities |

**Mission Goal:** Excellence in Service as Defined by Customers

| Operating Strategies | Performance Goals |
|---|---|
| **Implement Case Management/Coordination** | **'98:** Develop a methodology to assess advantages of maintaining patients within the network and develop appropriate transfer protocols between facilities<br>**'98:** Adopt demand management as a clinical tool network-wide<br>**'99:** Establish criteria for admission to acute and chronic care programs based on levels of care (Network) |
| **Improve Customer Service Satisfaction** | **'98:** Develop access points according to the Network business plan<br>**'99:** Establish partnerships with service organizations in their primary service area to assist in conducting health fairs for their constituents<br>**'00:** Establish a toll free number at each medical center for general and medical information |



**Mission Goal:** Be an Employer of Choice

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Improve Employee Knowledge of VHA Mission** | **'98:** Incorporate into the performance evaluations of all leadership positions (service chiefs, product line managers, chiefs of staff, associate directors, etc.) relevant medical center performance measures for the performance cycle which began 4/1/97<br>**'98:** Add into the performance requirements of all employees the national and network performance contract/measurement objectives relevant to the employees' duties<br>**'00:** Use results of the "One VA" employee survey to determine areas of strengths and weaknesses in terms of being an employer of choice |
| **Empower Employees** | **'98:** Reward the network medical centers based on performance<br>**'99:** Conduct network-wide training on the specific data base KLF for key staff from all network medical centers to provide a better understanding of the sources and programming involved in producing this data<br>**'00** Develop and train a cadre of employees, gifted in public relations skills, regardless of occupation, who can serve as VA ambassadors to the community through civic involvement |

## 1997 SELECTED ACCOMPLISHMENTS

- Implemented a network-wide strategic planning process, successfully integrating stakeholder and employee buy-in. The outcome consensus-building approach resulted in 150 recommendations for process improvements in clinical and administrative functions.
- Policy and system developed for funding VISN level outcomes management and research initiatives
- Established four primary/preventive care contracts and five additional awaiting approval
- Sharing agreement with affiliate arranged for rural CBOC was accomplished
- VA staffed CBOC for Charleston, WV proposed and submitted for VHA and congressional reviews
- Implemented integrated outcomes-based approaches to quality improvement and utilization management
- Assessed the feasibility of using community-based extended care resources in Memphis in lieu of operating the VA extended care unit to more efficiently meet patient's long-term care needs
- Evaluated the feasibility of rebuilding the cardiothoracic surgery program at Lexington resulting in decision to provide services at other network facilities and through contract for '98 and re-evaluate in '99
- VISN signed letter of intent for contract for TriCare status in Kentucky and West Virginia
- Reduction of inpatient beds provided $.5M to provide additional ambulatory services
- Developed policy for funding costs for CBOC implementation within the VISN
- Formed work group to establish a consolidated, competitive contract for community-based mental health and extended care services
- Developed criteria and system for funding VISN level projects to support outcomes management and research
- Successfully negotiated a contract between the Nashville VA and state of Tennessee for rural under-served areas
- Provided $.6M to Huntington VAMC for implementation of electronic (computerized) patient record (CPRS)
- Provided activation funding for Memphis VAMC ($3.8M) major construction project
- Full implementation of the Decision Support System by all medical centers in the network

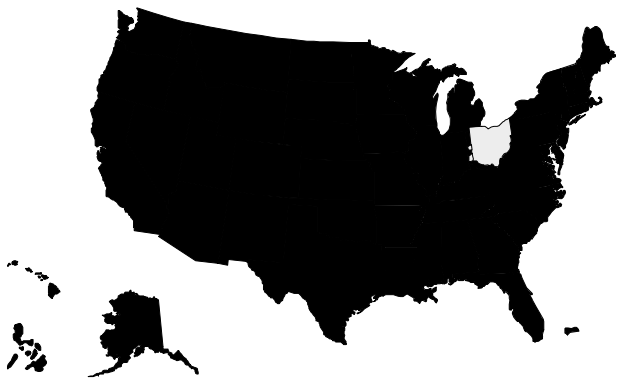
***Information as of December 12, 1997. The financial and workload information presented in this package is currently under review for use in budget justifications submitted to Congress.***

**BUDGETARY DATA SET (VISN 9)** **Table B-1**

| | 1997 Base | 1998 Tactical | 1999 Strategic | 2000 Strategic | 2001 Target | 2002 Target | 2003 |
|---|---|---|---|---|---|---|---|
| **1. Financial ($'s in thousands):** | | | | | | | |
| a. Medical Care, Sources of Funding: | | | | | | | |
| VERA Allocation for Medical Care | $699,955 | $698,539 | $698,539 | $698,539 | $698,539 | $698,539 | |
| MCCR Collection [See Note] | $0 | $31,033 | $34,959 | $38,646 | $41,975 | $45,481 | |
| Medicare Reimbursement | $0 | $0 | $0 | $0 | $13,500 | $15,500 | |
| Tricare Collection | $0 | $2,250 | $4,500 | $5,250 | $6,100 | $7,100 | |
| Other Sharing/Reimbursements | $3,300 | $5,500 | $6,700 | $7,800 | $9,300 | $10,000 | |
| Planned Unobligated Balances | | | | | | | |
| **Total = Allocation + Revenues** | $703,255 | $737,322 | $744,698 | $750,235 | $769,414 | $776,620 | $0 |
| b. Percent Revenues to Allocation + Revenues | 0.47% | 5.26% | 6.20% | 6.89% | 9.21% | 10.05% | |
| c. Distribution of Funding by selected activities: | | | | | | | |
| Acute Hospital Care | $294,769 | $288,951 | $281,158 | $273,198 | | | |
| Outpatient Care | $242,180 | $248,711 | $259,425 | $270,174 | | | |
| Long-Term Care | $83,025 | $83,138 | $83,589 | $84,016 | | | |
| Total | $619,974 | $620,800 | $624,172 | $627,388 | | | |
| **2. Federal Employment:** | | | | | | | |
| Average Employment (FTE), Total | 9,305 | 9,030 | 8,830 | 8,755 | | | |
| **3. Unique Patient Users (PRPs): [Unduplicated at the National Level]** | | | | | | | |
| a. Total Unique Patient Users (PRPs) | 146,632 | 152,497 | 158,902 | 165,894 | 172,530 | 180,124 | 183,726 |
| Percent Increase/Decrease from 1997 Base | | 4.00% | 8.37% | 13.14% | 17.66% | 22.84% | 25.30% |
| b. Distribution of PRPs by Eligibility Category: | | | | | | | |
| Category A | 127,524 | 132,652 | 138,274 | 144,144 | | | |
| Category C | 5,330 | 5,543 | 5,739 | 5,998 | | | |
| Non-Veteran Users | 13,778 | 14,302 | 14,889 | 15,752 | | | |
| Total | 146,632 | 152,497 | 158,902 | 165,894 | | | |
| c. Distribution of PRPs by VERA Patient Groups: | | | | | | | |
| Special Care Unique Patient Users | 6,535 | 6,561 | 6,610 | 6,700 | | | |
| Basic Care Unique Patient Users | 140,097 | 145,936 | 152,292 | 159,194 | | | |
| Total | 146,632 | 152,497 | 158,902 | 165,894 | | | |
| **4. Workload Episodes:** | | | | | | | |
| a. Outpatient Visits (Staff & Fee) | 1,311,779 | 1,429,839 | 1,544,226 | 1,652,322 | | | |
| b. Acute Hospital Care: | | | | | | | |
| Acute Hospital Beds | 962 | 862 | 750 | 700 | | | |
| Acute Hospital ADC | 646 | 625 | 610 | 595 | | | |
| Acute Inpatients Treated | 30,468 | 28,335 | 26,351 | 25,200 | | | |
| c. Long-Term Care: | | | | | | | |
| Long-Term Beds | 1,722 | 1,690 | 1,680 | 1,670 | | | |
| Long-Term ADC | 1,621 | 1,610 | 1,590 | 1,580 | | | |
| Long-Term Inpatients Treated | 8,418 | 8,495 | 8,530 | 8,590 | | | |
| **5. Number of Facilities:** | | | | | | | |
| VA Hospitals | 8 | 8 | 8 | 8 | | | |
| VA Nursing Home Care Units | 3 | 3 | 3 | 3 | | | |
| VA Domiciliaries | 1 | 1 | 1 | 1 | | | |
| Outpatient Clinics: | | | | | | | |
| Hospital Based, Independent & Mobile | 7 | 7 | 7 | 7 | | | |
| CBOCs, CBCs, Satellite & Outreach | 3 | 8 | 11 | 14 | | | |
| **6. Financial Measures (Medical Care):** | | | | | | | |
| a. Obligations Per Unique User Analysis (30% network goal): | | | | | | | |
| Obligations Per Unique User | $4,796 | $4,835 | $4,687 | $4,522 | $4,460 | $4,312 | $0 |
| Percent Change from 1997 Base | | 0.81% | -2.27% | -5.71% | -7.01% | -10.09% | -100.00% |
| Assumed Portion Current Services | | 3.75% | 7.63% | 11.63% | 15.45% | 19.92% | 24.28% |
| Percent Change Net of Current Services | | -2.94% | -9.90% | -17.34% | -22.46% | -30.01% | -124.28% |
| b. % Change in Unique Patient Users from 1997 base, from line 2a. above (20% network goal) | | 4.00% | 8.37% | 13.14% | 17.66% | 22.84% | 25.30% |
| c. % Revenues to Allocation + Revenues, from line 1b. above (10% network goal) | 0.47% | 5.26% | 6.20% | 6.89% | 9.21% | 10.05% | |
| d. % of Acute Hosp.$s to Tot.of Acute $s + OP $s | 54.90% | 53.74% | 52.01% | 50.28% | | | |
| e. Outpatient Visits Per Unique User | 8.95 | 9.38 | 9.72 | 9.96 | | | |
| f. Med. Care Capital Obligations Per Unique User | $237 | $247 | $218 | $209 | | | |

# VA HEALTHCARE SYSTEM OF OHIO (NETWORK 10)
PLAN SUMMARY

## VISN OVERVIEW



All facilities are located in the state of Ohio (except the NHCU at Fort Thomas, Kentucky). Greatest driving distance between network facilities is 220 miles. Northern and southern clusters represent groups of facilities within 90 minutes of each other. The majority of the planning and implementation efforts of the network deal with the development of a service line management structure. The network has a number of strategies in place that will increase access to healthcare. The estimated 1997 veteran population is 1,076,500 with 82 percent of veterans living within 50 miles of a VA facility.

## PLAN HIGHLIGHTS

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|---|---|
| ***Quality*** | • Further analyze and refine the utilization review plan which encompasses pre-admission certification and continued stay reviews<br>• Rehabilitation care service line will develop a plan to ensure CARF accreditation<br>• Provide clinical guidelines/pathways training |
| ***Performance Measurement System*** | • Develop palliative care performance measure<br>• Develop chronic disease index/prevention index performance measures<br>• Establish uniform functional measures for mental health patients<br>• Study need to develop productivity standards for the medical/surgical specialty service line<br>• Evaluate adult day healthcare against other effective community programs<br>• Mental Health Service Line will begin the development of extracts from current VHA data systems that will feed into Provider and Program Report Cards on productivity, quality (process and limited outcome data), and access |

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|---|---|
| ***Customer Service*** | • Attain customer service survey scores similar to those in the private sector over the next three years<br>• Improve customer service standards through the use of customer surveys |
| ***Primary Care/Case Management*** | • Implement a consistent model of case management across the network<br>• Expand community case management for the seriously mentally ill<br>• Initiate network-wide influenza/pneumococcal vaccine program<br>• Provide case management training<br>• Ambulatory care addition at Chillicothe will provide space for primary care and other outpatient functions<br>• Ambulatory care addition and parking garage at Cleveland to correct deficiencies and enable physicians to see more patients |
| ***Special Emphasis Programs and Six Disabling Conditions*** | • Examine network's ability to provide gender specific services (women's services)<br>• Evaluate need for dedicated Traumatic Brain Injury (TBI) Service<br>• Evaluate need for Blind Rehabilitation Service<br>• Expand dental service to target SCI populations<br>• Implement telemedicine project for SCI patients and network professional staff<br>• Increase number of mental health/substance abuse clinics to 15<br>• Increase total aid to veterans from contracts for Compensated Work Therapy to over $1 million each year<br>• Outplace PTSD treatment staff in community agencies<br>• Redistribute VIST resources across the network<br>• Complete implementation of Automated Fabrication of Mobility Aids (AFMA)<br>• Implement Progressive Dementia Unit in Cleveland<br>• Establish community case management teams from the mental health service line for the seriously mentally ill in the three largest network cities (Cincinnati, Dayton, and Columbus)<br>• Begin development of extracts from current VHA data systems that will feed report card sections for the mental health service line<br>• Explore the feasibility of providing specialty SCI primary care to patients at any network facility |
| ***Community Based Outpatient Clinics (CBOCs)*** | • Lima; Springfield; Portsmouth; Zanesville; Akron; Mansfield ('98)<br>• Painesville; Cleveland Downtown; Cleveland West Side; Troy; Medina; Northern Kentucky ('99)<br>• Richmond IN; Ravenna ('00)<br>• Washington Courthouse; Clermont County; Hillsboro; Marietta; Southeastern Indiana ('01)<br>• Lancaster; Trumbull County ('02) |
| ***Community Based Care Initiatives*** | • Expand detoxification services<br>• Provide improved services for incarcerated veterans about to be released into the community<br>• Expand community case management efforts<br>• Investigate more intensive home healthcare delivery provided by contracts, especially in rural areas |

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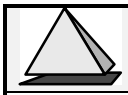
|---|---|
| ***Service Lines*** | • Expand mental health service line: emphasize outpatient care<br>• Primary care service line will assume operational responsibility for all CBOCs within the network in FY98<br>• Include women veteran's services within the Primary Care Service Line<br>• Medical/surgical specialty service line will investigate avenues for obtaining specific types of diagnostic testing and assessments to reduce unnecessary admissions<br>• Extended care service line will implement review of all nursing home (VA and non-VA) capabilities available to the network<br>• Extended Care Service Line will study integration of management for nursing home care units, community nursing homes, home-based primary care, home health and other programs<br>• Clinical support service line will evaluate the feasibility of realigning certain dental laboratory functions within the network over the next three to five years |
| ***Improving Clinical and Administrative Information Systems*** | • Establish an information management system for the Mental Health Service Line in conjunction with the network Decision Support System (DSS) to develop provider and program report cards |
| ***Communication*** | • Publish bi-weekly and bi-monthly newsletters to keep employees and other important stakeholders apprised of network activities<br>• Network Director meets with the presidents of the unions and holds town hall and small focus group meetings with facility employees on a quarterly basis<br>• Each of the five facilities conducts various town hall and focus group meetings in an effort to increase communication with employees<br>• Publish and distribute Patient Magazine on a quarterly basis |
| ***Education*** | • Promote the VA as educator within the community working with veterans service organizations and others<br>• Begin benchmarking patient education best practices<br>• Identify effective patient education strategies for implementation of clinical guidelines and other patient education initiatives<br>• Develop patient education programs<br>• Study need for network-wide education services office<br>• Develop and implement case management training |
| ***Research*** | • Assess funding associated with patient-based research through the development of a peer review process<br>• Examine new approaches to research funding to include research corporations<br>• Place emphasis on VISN-wide research projects and initiatives<br>• Develop explicit goals for developing research capacity in priority areas |

| | |
|---|---|
| ***Sharing Agreements*** | • Establish homeless outreach centers<br>• Study feasibility of offering excess property (buildings) to other government agencies or community services<br>• Pursue agreement to provide medical examinations for active reservist personnel<br>• Explore possibilities of providing viral load testing for other VISNs or non-VA organizations<br>• Evaluate the potential to offer excess advance food preparation to other governmental agencies<br>• Evaluate the potential to offer excess laundry capacity to other governmental agencies<br>• Continue expanding the tele-nurse coverage to other VISNs and non-VA organizations |
| ***Contracting Services*** | • Provide therapeutic milieu for patients that are undergoing intensive outpatient programming but lack a stable environment to facilitate rehabilitation through contractual arrangement with community providers of residential services<br>• Consolidate contract-marketing efforts on a state-wide basis for therapeutic work program<br>• Mental Health Service Line will enter a competitive bid for vocational services currently provided on a contractual basis by VBA throughout Ohio<br>• Mental Health Service Line will submit a bid to provide psychosocial services as part of a multi-service center<br>• Pursue subcontractor status to TriCare's prime contractor for CHAMPUS beneficiaries health care<br>• Negotiate a contract with the Great Lakes Naval Center to provide healthcare to active duty personnel<br>• Mental Health Service Line to expand alliances with employee assistance programs at employers with large veteran representations in their work force to maximize referrals<br>• Expand contractual mental health services at Wright Patterson Air Force Base (DOD collaboration)<br>• Implement state-wide home health contract |
| ***Managing Human Resources*** | • Continue to review positions using position classification audits to ensure the new supervisory ratios are reflected<br>• Continue offering training on Interest Based Bargaining to provide staff with necessary skills to carry forward with upcoming organizational realignments<br>• Continue implementing network-wide supervisory training<br>• Continue with use of core competencies in selection of service line personnel<br>• Develop a mentoring program for positions that would serve as advancement opportunities for employees<br>• Offer stress management training as the need arises<br>• Offer "Violence in the Workplace" training as needed<br>• Offer pertinent safety training for each position within the network<br>• Develop a network-wide Alternative Dispute Resolution program in conjunction with labor partners |

| | |
|---|---|
| ***Facility and/or Service Consolidations*** | • Develop a proposal aimed at achieving economies of scale through a consolidated business office<br>• Implement network consolidated lab testing<br>• Implementation of consolidated laundry – Dayton and Chillicothe<br>• Eliminate Assistant Chief positions as opportunities are afforded<br>• Evaluate the feasibility of realigning certain dental laboratory functions within the network<br>• Study need for network-wide fee services office<br>• Develop proposal for network-wide 3RD party payment office<br>• Review need for consolidated entity for credentialing and privileging across the network |
| ***Emergency Preparedness*** | • Currently recruiting volunteer disaster responders for support in emergencies |

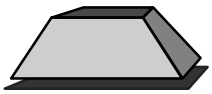

## NETWORK STRATEGIC PLAN SUMMARY



**Mission Goal:** Increase Health Care Users

**Operating Strategies**

**Increase Access to Veteran Users**

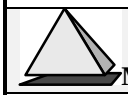


**Performance Goals**

**'98:** Evaluate establishment of a long-term SCI/SCD Unit at Brecksville Division

**'98:** Evaluate need for local inpatient services in Columbus

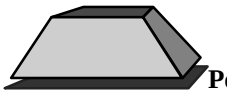
**'98-02:** Increase number of Community-Based Outpatient Clinics (CBOCs)



**Mission Goal:** Decrease Cost per Patient

**Operating Strategies**

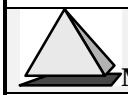
**Shift Focus from Inpatient to Outpatient Care**



**Performance Goals**

**'98:** Increase ambulatory surgery procedures in specific high-volume areas

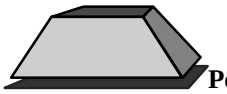
**'98:** Continue monitoring utilization to determine potential decreases in operating bed numbers



**Mission Goal:** Enhance Primary Care Program

**Operating Strategies**

**Increase Primary Care Standardization**



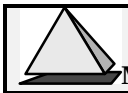
**Performance Goals**

**'98:** Standardize provider team and panel size

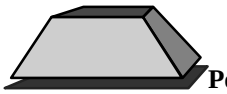
**'98-00:** Continue recruitment of physician extenders

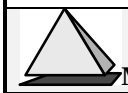
**'00-02:** Study the opportunity for using clinical pharmacy specialists as physician extenders

| | |
|---|---|
| **Mission Goal:** Comprehensive Quality and Organizational Accountability Framework | |
| **Operating Strategies** | **Performance Goals** |
| **Manage Population Through Use of Evidence-Based Clinical Guidelines** | '**98**: Develop additional clinical guidelines in accordance with '98 performance measures and identified needs of the patient population |
| **Mission Goal:** Improve Customer Satisfaction | |
| **Operating Strategies** | **Performance Goals** |
| **Improve Customer Service Standards** | '**98-00:** Network will implement a customer service program based on proven principles as in the Malcolm Baldridge Performance Improvement Criteria and the nine critical success factors of customer service identified by the employee education system |
| **Development of Patient Education Programs** | '**98:** Develop patient education magazine into quarterly publication<br>'**98:** Coordinate implementation of an integrated network-wide patient education program<br>'**98-99:** Develop network-wide health promotion tools |
| **Communicating with Stakeholders** | '**98:** Network Director will continue to hold quarterly meetings with labor representatives, town hall meetings with employees at each facility, and focus groups<br>'**98:** Continue publishing bi-weekly and bi-monthly newsletter for employees and external stakeholders on items of network interest<br>'**98:** Increase external stakeholder collaboration through continued support of the Management Assistance Council (veterans service organizations, labor unions, state and local officials and non-VHA VA officials), meetings with congressional delegations, the Network Mental Health Consumer Advisory Council and the Rehabilitation Care Council |

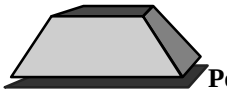


**Mission Goal:** Be a Leader in Research and Education

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Promote Research Related to Healthcare of Veterans** | **'98**: Develop network-wide research areas of concentration and new funding sources |
| **Develop Provider Education with a Patient Focus** | **'98-99**: Continuing education for accent reduction will be offered to providers for whom English is a second language<br>**'98-99:** The network will be moving forward with the initiative to increase employee education in the areas of quality improvement and customer service to 40 hours per year<br>**'98-99:** The network will be developing an assessment tool to evaluate network-wide residency and fellowship programs at affiliated medical centers |



**Mission Goal:** Be an Employer of Choice

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Establish Career Development Services** | **'98-00:** Provide job placement counseling services to those employees directly impacted by reductions-in-force or organizational realignments<br>**'98-00:** Provide ongoing EEO training on a network-wide basis in an effort to further reduce EEO complaints<br>**'98-00:** The network will move forward with the initiative to increase employee education in the areas of QI and customer service to 40 hours per year |
| **Provide a Safe and Friendly Workplace** | **'98-00:** Continue to monitor conditions at network facilities for possible safety issues<br>**'98-00:** Address concerns brought out by "One VA" survey<br>**'98-00:** Continue developing strong corporate identity as integrated delivery system |

## 1997 SELECTED ACCOMPLISHMENTS

- Established CBOCs in Athens and Lorain
- Implemented Pathology and Laboratory Medicine Service initiative network-wide that restructured activities and resulted in overall cost avoidance savings of over $2 million
- Hired full-time social worker to lead and implement Columbus homeless services
- Contracted with local mental health /substance abuse public sector treatment programs for outplacement of VA staff on weekly basis
- Advanced food preparation equipment purchased and installed at VAMCs Chillicothe and Cleveland
- Laundry consolidation for VAMCs Dayton and Chillicothe feasibility study
- VAMC Cincinnati designated brachytherapy referral center
- Expanded tele-nurse program to include veterans from VISNs 2 and 17
- Recruited additional 9.4 physician extenders
- Instituted 15 clinical guidelines (including diabetes, stroke, congestive heart failure, etc.)
- Began development of teaching skills for network clinical staff to promote integration of patient education
- Coding symposium provided employees. Focus of this session was to stress the importance of coding to our network funding (to be provided to clinicians in '98)
- Reduced operating beds by 25 percent
- Identified 14 functions for realignment or reengineering
- Contracted with Ohio University College to provide physician coverage at the CBOC in Athens
- Selected Service Line Directors and Business Managers for each of the six service lines.
- Improved National Customer Feedback Center survey scores for both inpatient and outpatient services
- Provided basic health services at state and county health fairs
- Reduced BDOC by 30 percent for the network
- Consolidated Compensation and Pension Exam workload from Chillicothe to IOC Columbus
- Implemented Phase I of Laboratory Service consolidation
- Initiated HCMI outreach program at IOC Columbus
- Piloted a new patient education magazine
- Conducted a long-term mission review at Chillicothe
- Established 30 Psychosocial Residential Rehabilitation Treatment Program Beds at Chillicothe

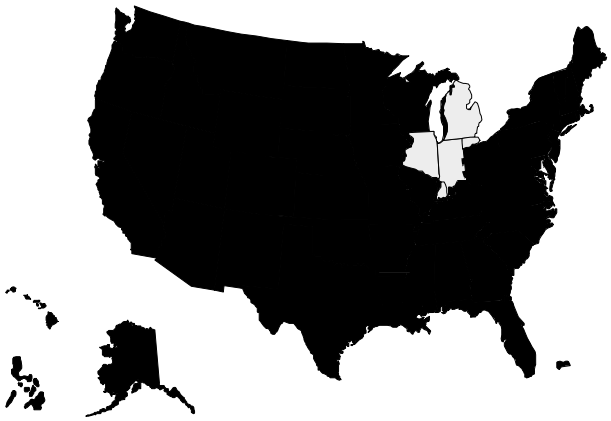
***Information as of December 12, 1997. The financial and workload information presented in this package is currently under review for use in budget justifications submitted to Congress.***

**BUDGETARY DATA SET (VISN 10)** **Table B-1**

| | 1997 Base | 1998 Tactical | 1999 Strategic | 2000 Strategic | 2001 Target | 2002 Target | 2003 Target |
|---|---|---|---|---|---|---|---|
| **1. Financial ($'s in thousands):** | | | | | | | |
| a. Medical Care, Sources of Funding: | | | | | | | |
| VERA Allocation for Medical Care | $530,331 | $527,925 | $527,925 | $527,925 | $527,925 | $527,925 | $527,925 |
| MCCR Collection [See Note] | $0 | $20,517 | $25,340 | $29,803 | $34,027 | $38,502 | $44,502 |
| Medicare Reimbursement | $0 | $0 | $0 | $0 | $5,140 | $15,419 | $25,419 |
| Tricare Collection | $0 | $100 | $300 | $500 | $700 | $900 | $900 |
| Other Sharing/Reimbursements | $2,002 | $2,202 | $2,643 | $3,171 | $3,488 | $3,837 | $4,337 |
| Planned Unobligated Balances | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Total = Allocation + Revenues** | $532,333 | $550,744 | $556,208 | $561,399 | $571,280 | $586,583 | $603,083 |
| b. Percent Revenues to Allocation + Revenues | 0.38% | 4.14% | 5.08% | 5.96% | 7.59% | 10.00% | 12.46% |
| c. Distribution of Funding by selected activities: | | | | | | | |
| Acute Hospital Care | $161,187 | $163,760 | $157,519 | $151,169 | | | |
| Outpatient Care | $185,100 | $194,136 | $207,693 | $216,300 | | | |
| Long-Term Care | $95,348 | $95,082 | $97,935 | $100,873 | | | |
| Total | $441,635 | $452,978 | $463,147 | $468,342 | | | |
| **2. Federal Employment:** | | | | | | | |
| Average Employment (FTE), Total | 6,763 | 6,602 | 6,482 | 6,345 | | | |
| **3. Unique Patient Users (PRPs): [Unduplicated at the National Level]** | | | | | | | |
| a. Total Unique Patient Users (PRPs) | 106,385 | 108,783 | 112,381 | 117,177 | 123,173 | 130,368 | 130,400 |
| Percent Increase/Decrease from 1997 Base | | 2.25% | 5.64% | 10.14% | 15.78% | 22.54% | 22.57% |
| b. Distribution of PRPs by Eligibility Category: | | | | | | | |
| Category A | 100,534 | 102,800 | 106,200 | 110,732 | | | |
| Category C | 2,979 | 3,046 | 3,147 | 3,281 | | | |
| Non-Veteran Users | 2,872 | 2,937 | 3,034 | 3,164 | | | |
| Total | 106,385 | 108,783 | 112,381 | 117,177 | | | |
| c. Distribution of PRPs by VERA Patient Groups: | | | | | | | |
| Special Care Unique Patient Users | 5,200 | 5,317 | 5,493 | 5,728 | | | |
| Basic Care Unique Patient Users | 101,185 | 103,466 | 106,888 | 111,449 | | | |
| Total | 106,385 | 108,783 | 112,381 | 117,177 | | | |
| **4. Workload Episodes:** | | | | | | | |
| a. Outpatient Visits (Staff & Fee) | 1,058,744 | 1,000,799 | 942,656 | 887,859 | | | |
| b. Acute Hospital Care: | | | | | | | |
| Acute Hospital Beds | 646 | 581 | 552 | 538 | | | |
| Acute Hospital ADC | 631 | 552 | 538 | 531 | | | |
| Acute Inpatients Treated | 26,093 | 26,683 | 27,565 | 28,744 | | | |
| c. Long-Term Care: | | | | | | | |
| Long-Term Beds | 1,373 | 1,332 | 1,305 | 1,292 | | | |
| Long-Term ADC | 2,221 | 2,276 | 2,242 | 2,231 | | | |
| Long-Term Inpatients Treated | 7,251 | 7,469 | 7,618 | 7,694 | | | |
| **5. Number of Facilities:** | | | | | | | |
| VA Hospitals | 5 | 5 | 5 | 5 | | | |
| VA Nursing Home Care Units | 4 | 4 | 4 | 4 | | | |
| VA Domiciliaries | 3 | 3 | 3 | 3 | | | |
| Outpatient Clinics: | | | | | | | |
| Hospital Based, Independent & Mobile | 5 | 5 | 5 | 5 | | | |
| CBOCs, CBCs, Satellite & Outreach | 4 | 12 | 18 | 20 | | | |
| **6. Financial Measures (Medical Care):** | | | | | | | |
| a. Obligations Per Unique User Analysis (30% network goal): | | | | | | | |
| Obligations Per Unique User | $5,004 | $5,063 | $4,949 | $4,791 | $4,638 | $4,499 | $4,625 |
| Percent Change from 1997 Base | | 1.18% | -1.10% | -4.26% | -7.31% | -10.09% | -7.57% |
| Assumed Portion Current Services | | 3.75% | 7.63% | 11.63% | 15.45% | 19.92% | 24.28% |
| Percent Change Net of Current Services | | -2.57% | -8.73% | -15.89% | -22.76% | -30.01% | -31.85% |
| b. % Change in Unique Patient Users from 1997 base, from line 2a. above (20% network goal) | | 2.25% | 5.64% | 10.14% | 15.78% | 22.54% | 22.57% |
| c. % Revenues to Allocation + Revenues, from line 1b. above (10% network goal) | 0.38% | 4.14% | 5.08% | 5.96% | 7.59% | 10.00% | 12.46% |
| d. % of Acute Hosp.$s to Tot.of Acute $s + OP $s | 46.55% | 45.76% | 43.13% | 41.14% | | | |
| e. Outpatient Visits Per Unique User | 9.95 | 9.20 | 8.39 | 7.58 | | | |
| f. Med. Care Capital Obligations Per Unique User | $241 | $240 | $234 | $226 | | | |

# VA VETERANS INTEGRATED SERVICE NETWORK (NETWORK 11)
PLAN SUMMARY

## VISN OVERVIEW



Healthcare delivery service covers the lower peninsula of Michigan, northwest Ohio, Indiana and central Illinois. The estimated FY97 veteran population is 1,538,400. About 5 percent of the population is women veterans. The network plans to accommodate the projected 20% increase in unique veteran users through utilization improvements within current physical capacity and through contracts with a variety of community providers. Eighty percent of the veteran population within the network lives within 50 miles of a current VA medical care site. Continued improvements in access to primary care to achieve the network goal of "30 minutes or 30 miles" will be accomplished through the establishment of VA staffed or contract-for-service community based outpatient clinics.

## PLAN HIGHLIGHTS

| | |
|---|---|
| ***Quality*** | • Develop network-wide clinic effectiveness tools that address utilization, scheduling issues, no shows, cancellations, etc.<br>• Increase efficiency by reducing management and organizational layering through re-engineered structures and processes<br>• Maintain quality imaging services by replacing angiography unit at VAMC Indianapolis<br>• Increase the quality of inpatient space through a minor construction project at Ann Arbor to improve patient privacy on two wards<br>• Improve the quality of facilities for acute psychiatry beds at Marion campus of NIHCS through replacement |
| ***Performance Measurement System*** | • Create network performance measures to identify causes of and solutions for lengthy delays in scheduling new clinic appointments<br>• Review quality of life and functional status measures, then selectively implement as appropriate<br>• Develop methods for benchmarking network performance against national or community performance |

| | |
|---|---|
| ***Customer Service*** | • Provide 40 hours of training to every network employee on customer satisfaction or performance<br>• Pilot and evaluate implementation of video kiosks for disseminating information to patients and obtaining patient feedback<br>• Implement communication program to give patients more control of their treatment experience<br>• Develop plan for implementing patient satisfaction review at point of contact<br>• Identify data requirements to be stored on veteran's ID card<br>• Export jointly developed (with VBA) educational curriculum for C&P examinations<br>• Design and implement simulation model of patient flow through outpatient clinics to identify solutions to long patient waiting times in clinics<br>• Develop strategic plan for customer satisfaction |
| ***Primary Care/Case Management*** | • Evaluate possibility of establishing primary care service line<br>• Increase use of temporary lodging programs<br>• Develop case management models<br>• Establish VISN-wide utilization review program<br>• Develop a prioritized list of wellness initiatives with emphasis on minority populations<br>• Award minor construction project to renovate and expand ambulatory care space at Battle Creek. Shift substance abuse treatment to the outpatient setting<br>• Continue to increase the number of surgical and invasive diagnostic procedures performed in an outpatient setting<br>• Increase use of non-physician advanced practitioners<br>• Complete ambulatory care addition projects at Ann Arbor, NIHCS and at Fort Wayne |
| ***Community Based Outpatient Clinics (CBOCs)*** | • Implement Yale, MI and South Bend, IN in FY98.<br>• Identify twelve more potential CBOC sites<br>• Develop proposals for Central Indiana, Southeast Michigan, and Springfield, IL in FY98 |
| ***Community Based Care Initiatives*** | • Develop a data driven, prioritized plan for the continued shift of inpatient services to outpatient and/or community settings<br>• Negotiate for use of excess community resources where demand for service exists, where quality care can be maintained, and cost efficiencies realized<br>• Evaluate community-based resources to meet unmet veteran demand in under-served areas<br>• Pilot sharing agreement with community providers where VA provides specialty services in exchange for primary care |

| | |
|---|---|
| ***Service Lines*** | • Continue development of mental health and extended care service line proposals<br>• Evaluate feasibility of primary care service line<br>• Include key stakeholders in service line development |
| ***Improving Clinical and Administrative Information Systems*** | • Use DHCP (VISTA) for scheduling and transfer of progress notes across the network<br>• Develop network consults package<br>• Fully implement DSS and target use by relevant clinicians and administrators<br>• Use DSS and clinical consultation to develop physician specific reporting systems for comparative analysis<br>• Link network with information databases external to VHA and VA<br>• Develop information database on veterans receiving care under Medicare and in the VA<br>• Establish LANs at facilities that interface with VA-wide area telecommunications networking environments<br>• Install Microsoft Exchange mail services at all network facilities |
| ***Communication*** | • Improve communications between clinicians and patients through training staff in satisfaction techniques to help patients better understand the level of care they receive<br>• Communicate the strengths of care provided to stakeholders using outstanding external review scores, outreach efforts and comparative outcome data<br>• Review, select, implement and evaluate network-wide training program for improving communication between clinicians and patients |
| ***Education*** | • Establish and charge Network Education Board with developing overall strategy for patient and employee education throughout the network<br>• Develop inventory of national and local education and training resources<br>• Develop network employee education tracking system<br>• Charge Patient Education Committee with developing action plans<br>• Charge Employee Education and Development Committee with developing action plans<br>• Collaborate with Employee Education System to develop educational initiatives<br>• Implement plans to meet resident allocation goal |
| ***Research*** | • Support research efforts on programs for improving communication and shared decision-making between patients and clinicians<br>• Obtain and disseminate information describing research opportunities to study alternative therapies<br>• Use Research Realignment Review Committee report to evaluate research programs in the network |
| ***Sharing Agreements*** | • Investigate opportunities for sharing agreements with federal prisons and Coast Guard |

| | |
|---|---|
| ***Contracting Services*** | • Enhanced use project between State of Indiana and VA at Cold Springs Road property (VAMC Indianapolis)<br>• Private vendor solicitation for VA nursing home services at West Tenth Street (VAMC Indianapolis)<br>• Collect proceeds from operation of golf courses, rental of space for day care and health services<br>• Explore future revenue generating agreements, e.g. rental of excess space<br>• Reduce contract hospitalization costs by 10 percent |
| ***Managing Human Resources*** | • Increase employee training and career development opportunities<br>• Provide ongoing training to managers and facilitators in informal resolution strategies<br>• Support local partnerships through joint efforts in planning and organizational development<br>• Evaluate and pilot test skill assessment inventory instruments for uniform application throughout network<br>• Appoint and charge Employee Education and Development Committee<br>• Develop strategic plans for employee education<br>• Expand upward mobility programs<br>• Provide training in reimbursement methodology/capitation system for clinical and administrative staff |
| ***Facility and/or Service Consolidations*** | • Explore potential for integrating business office functions<br>• Develop proposals for consolidation of laboratory and radiology<br>• Continue to refine integration across Northern Indiana VAHS campuses |


## NETWORK STRATEGIC PLAN SUMMARY

**Mission Goal:** Geographically Dispersed Primary Care Delivery Sites Provide Convenient Access for Veterans Through Variety of Provider Mechanisms

| Operating Strategies | Performance Goals |
|---|---|
| **Improve Access to Primary Care** | **'98:** CBOC Development Committee will continue proposal development for additional CBOC sites<br>**'98-99:** Develop method for evaluating services and satisfaction which will include evaluation of effect CBOCs have on attracting new veterans<br>**'99-00:** Explore benefit of providing GUI to clinics |

**Mission Goal:** Veterans Rate VA Healthcare in VISN 11 Higher Overall Than Private Sector Patients Rate Their Care

| Operating Strategies | Performance Goals |
|---|---|
| **Implement a Network-Wide Program for Improving Customer Satisfaction** | **'98:** Publicize best practices from network facilities<br>**'98:** Organize network customer surveys to provide feedback by service lines<br>**'99:** Evaluate all programs for possible implementation of a single program network wide<br>**'99-00:** Develop patient satisfaction measure based on routine feedback from patients (in addition to formal survey results) |
| **Recognize Significant Achievements in Customer Service** | **'98-99:** Survey other VISNs for information on education and reward programs designed to improve customer satisfaction<br>**'99-00:** Incorporate successful components of other VISNs' programs in VISN 11 plans |

**Mission Goal:** Corporate Structure Supports Integrated Health Services Network and Continually Evolves in Response to Changing System Requirements

| Operating Strategies | Performance Goals |
|---|---|
| **Evaluate Corporate Structure on an Ongoing and Formal Basis to Ensure it Supports System** | **'98:** Develop process for evaluating corporate structure of network<br>**'98-99:** Develop evaluation format<br>**'99-00:** Complete evaluation and analysis, and make appropriate changes |
| **Conduct Strategic and Tactical Planning to Create Integrated Health Services Network Responsive to Domains of Care** | **'98:** Develop methods for assessment of market, and customer satisfaction<br>**'98-99:** Conduct assessments<br>**'99-00:** Assign priorities for capital improvements, program enhancements and consolidations |

**Mission Goal:** Service Delivery Is Structured Across VISN 11 to Achieve Maximum Benefit from Available Resources

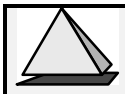
| Operating Strategies | Performance Goals |
|---|---|
| **Develop and Utilize a Managed Care Delivery System** | **'98:** Develop a data driven, prioritized plan for the continued shift of inpatient services to outpatient and/or community settings<br>**'98-99:** Establish network-wide utilization review program<br>**'99-00:** Reduce ALOS and place veterans in least restrictive care setting, as appropriate to their care needs |
| **Integrate Special Emphasis Programs across the Network** | **'98:** Develop formal recommendations to Network Director and ELC for distribution of special emphasis program care across the network<br>**'98-99:** Implement recommendations<br>**'99-00:** Monitor and evaluate outcomes of recommendations |

**Mission Goal:** Use Sophisticated Technology to Increase Access to Specialized Expertise

| Operating Strategies | Performance Goals |
|---|---|
| **Use Telemedicine At All Primary Care Sites** | **'98:** Develop a prioritized plan for VISN telemedicine<br>**'98-99:** Evaluate telemedicine initiatives offered by other networks<br>**'99-00:** Begin procurement of telemedicine equipment |

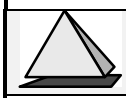
**Mission Goal:** Optimize Utilization of Capacity and Minimize Duplication of Service Within VA, and Between VA and the Community

| Operating Strategies | Performance Goals |
|---|---|
| **Negotiate for Use Of Excess Community Resources** | **'98:** Evaluate unmet primary healthcare needs throughout VISN<br>**'98-99:** Evaluate community-based resources to meet unmet veteran demand in under-served areas.<br>**'99-00:** Develop model to determine needs for extended care services across a continuum |
| **Determine If Excess Network Capacity Should Be Eliminated Or Used To Provide Services To Community** | **98:** Explore realignment of orthopedic surgery and head and neck surgery programs between Ann Arbor and Detroit<br>**'98-00:** Evaluate cross-section of six clinical and administrative programs for which VA has excess capacity<br>**'98-99:** Pilot sharing agreement with community where VA provides specialty services in exchange for primary care |



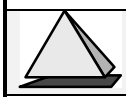
**Mission Goal:** Provide Safe, Secure, and Functional Environments for Patients, Employees, and Visitors

| Operating Strategies | Performance Goals |
|---|---|
| **Develop and Implement Prioritized Plans to Improve Physical Plant Treatment Environments** | **'98:** Develop prioritized method for physical plant improvements across the network<br>**'98-99:** Survey network medical centers for status of inpatient amenities (phones, TVs, private bathrooms)<br>**'99-00:** Develop plan for improvement based on problem areas identified in survey |



**Mission Goal:** VA is Provider of Choice for Veterans in VISN 11

| Operating Strategies | Performance Goals |
|---|---|
| **Implement Comprehensive Network Communication Plan** | **'98:** Maintain current network Web page with key information |
| **Develop and Implement a Network-Wide Marketing Plan** | **'98:** Conduct analysis of veteran non-users<br>**'98-99:** Develop a public information plan<br>**'99-00:** Conduct market survey and develop a template for future application |



**Mission Goal:** Clinical Outcomes Exceed Community Standards

| Operating Strategies | Performance Goals |
|---|---|
| **Develop Clinical Guidelines to Maintain Consistent Care** | **'98:** Develop methods for benchmarking network performance against national or community performance (or thresholds) |
| **Identify Clinical Quality Measures VHA and/or Private Sector Standards** | **'98:** Develop methods for benchmarking network care with national VHA or community care (e.g. EPRP results, performance measures) |

**Mission Goal:** VISN 11 Is Recognized for High Quality of Care It Provides

| Operating Strategies | Performance Goals |
|---|---|
| **Network Will Pursue and Achieve External Accreditation** | **'98:** Begin preparation for being surveyed under JCAHO network standards |

**Mission Goal:** VISN 11 Contributes to Improved Veteran Health Status

| Operating Strategies | Performance Goals |
|---|---|
| **Develop ongoing mechanisms for the measurement of veteran health status** | **'98:** Review array of functional status and quality of life measures available, and select a limited number for implementation across all facilities<br>**'98-99:** Initiate mutual use of other available veteran data bases to identify veterans at risk for poor health status |
| **Promote wellness and increase veteran population in wellness activities** | **'98-00:** Develop list of priority wellness initiatives, including emphasis on minority population needs, for implementation across the network<br>**'98-00:** Develop method for evaluating customer satisfaction and clinical outcomes |

**Mission Goal:** Continuum of Care Includes Community Support Services

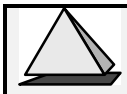
| Operating Strategies | Performance Goals |
|---|---|
| **Collaborate with Veterans Outreach Centers, VBA, HHS, SSA and other organizations to identify resources for veterans which build upon VISN initiatives** | **'98:** Build upon homeless initiatives, increase development of continuum services for high risk populations and participate in "healthy community"<br>**'98-99:** Assess current available resources and collaborate with other interested agencies to develop full continuum of services for homeless veterans across the network |

**Mission Goal:** VISN Education and Research Programs Contribute to Quality of Care for Veterans and Complement Clinical Delivery System

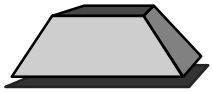
| Operating Strategies | Performance Goals |
|---|---|
| **Perform, Facilitate and Encourage Meritorious Research That Benefits Veterans** | **'98:** Encourage multiple center VA cooperative studies<br>**'98-99:** Develop a strategic plan for research<br>**'99-00:** Use Research Realignment Review Committee report to evaluate network research programs |
| **Implement Outstanding Medical/Health Education and Training Programs** | **'98:** ACOS/Es will coordinate medical center residency training programs that are consistent with VISN allocation targets<br>**'98-99:** Develop a strategic plan for affiliation management<br>**'99-00:** Reduce residency positions across the network |

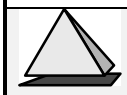
**Mission Goal:** Information Systems Are Integrated Across VISN 11

| Operating Strategies | Performance Goals |
|---|---|
| **Access and Share DHCP (VISTA) Information Across All Sites in Network** | **'98:** Conduct corporate information management assessment to determine information needed to support organizational structure and its ongoing evaluation<br>**'98-99:** Develop computerized information repository (CAIRO)<br>**'99-00:** Utilize DHCP (VISTA) package to support network health exchange and educate clinicians about its availability and use |

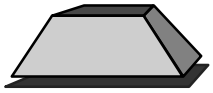


**Mission Goal:** Information Is Utilized Effectively to Manage Network Activities and Make Decisions Regarding Resources and Programs

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Establish Electronic Medical Records System that Integrates with DHCP (VISTA)** | **'98:** Implement "Chartman for Ambulatory Care" electronic medical record VISN wide<br>**'98-99:** Implement CPRS at VAMC Saginaw |
| **Implement DSS At All Network Facilities** | **'98:** Conduct review of sites' implementation efforts at key phases<br>**'98-99:** Purchase Microsoft software license<br>**'99-00:** Conduct DSS training/workshops |



**Mission Goal:** Technology Is Used to Conduct Business Efficiently and Enhance Sharing of Information

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Promote Use of Technology in Conducting Daily Business** | **'98:** Establish Network-wide video conference capability and provide training to users<br>**'98-99:** Provide employees convenient access to computers and necessary training to utilize them effectively |
| **Automate Standard Forms and Establish Reliable Mechanisms for Electronic Signature** | **'98:** Computerize travel authorities, travel vouchers, position descriptions, performance appraisal forms and requests for education and training<br>**'98-99:** Survey other federal agencies for computerized forms already in use |

**Mission Goal:** VISN 11 Demonstrates High Level of Commitment to Its Employees

| Operating Strategies | Performance Goals |
|---|---|
| **Establish Cultural Environment that Promotes Employee Commitment to Organization** | **'98:** Initiate training for all employees about new VA, values and behaviors that support excellence of service and VA's customer service standards<br>**'98-99:** Conduct employee surveys at all sites to evaluate current perceptions of leadership, communication, strategic planning, etc.<br>**'99-00:** Survey employees on key components of job satisfaction |
| **Demonstrate Commitment to Principles of Equal Opportunity and Provision of Workplace Free of Discrimination and Harassment** | **'98:** Conduct sexual harassment and diversity training for all employees |

**Mission Goal:** Performance and Reward Systems Promote Team Performance and Accountability

| Operating Strategies | Performance Goals |
|---|---|
| **Collaborate with HQ Program Officials to Establish Team Based Performance Standards and Awards** | **'98:** Develop initiatives, including education, to improve culture which promotes teamwork and cooperation |

**Mission Goal:** VISN 11 Achieves Optimal Utilization of Its Financial and Human Resources

| Operating Strategies | Performance Goals |
|---|---|
| **Develop a Network Financial Management Strategy** | **'98:** Develop cost/workload screens to identify outliers and develop specific actions for change<br>**'98-99:** Develop capital acquisition/improvement plan and funding plan that does not rely on traditional allocated non-recurring funds<br>**'99-00:** VISN 11 will recover $25 million (MCCF) while operating efficiently |
| **Develop Network Human Resources Plan that Enables Network to Meet Future Human Resource Needs** | **'98:** Assess number of FTE required to serve current workload (unique patients) |

**Mission Goal:** VISN 11 Prices Are Competitive With the Community

| Operating Strategies | Performance Goals |
|---|---|
| **Compare Network Prices with those of Community HMOs** | **'98:** Continue DSS implementation |
| **Ensure that Pricing Strategies Reflect Costs of Education and Research** | **'98:** Develop methodology in concert with national organizations to assess education and research costs and compensation |

**Mission Goal:** VISN 11 Maintains Operating Costs At or Below National VA Unit Cost Through Ongoing Systems Improvement

| Operating Strategies | Performance Goals |
|---|---|
| **Carry Out Intent of Performance Measures to Achieve Unit Cost Per Unique Veteran that is at or Below National Average** | **'98:** Implement CBOCs in Yale, MI and South Bend, IN<br>**'98-99:** Reduce fee-basis and contract care costs |
| **Reduce Pharmacy Cost Per Patient** | **'98:** Continue development of pharmacy benefits management system proposal |

## 1997 SELECTED ACCOMPLISHMENTS

- Began a centralized marketing effort
- Began development of SWOT analyses for each "10 for 2000" strategy
- All VISN 11 facilities participated in customer (patient) satisfaction surveys
- Began preliminary development of two service lines
- Developed several network-wide clinical policies
- Mental Health Task Force completed assessment of service delivery across the network
- Funded video conferencing infrastructure
- Funded teleradiology in Indiana and Illinois
- Assigned VISN staff member as State Veterans Home liaison who addressed 1997 national State Veterans Home Convention on behalf of network
- VAMC Ann Arbor worked with community health agencies and United Way to identify special program capacity
- VAMC Danville has a number of existing community contracts for laundry, golf course maintenance, clinical consultants in GYN, podiatry and cataract surgery
- Received approval to implement CBOC sites at Yale, MI And South Bend, IN
- Completed VA NIHCS 240-bed gero-psychiatric facility
- Effectively maintained Emergency Preparedness Program
- VISN 11 collaborated with VISN 12 in development of services available at State Veterans Home in Manteno, IL
- Worked with VISN 10 to develop their CBOC proposal at State Veterans Home in Sandusky, OH
- Three sites implemented focus groups
- Five of seven VAMCs instituted formal training programs for all staff
- Six of seven VAMCs instituted special awards for customer service
- Network reps visited VAMC Portland and VISN 2 to learn about successful programs for improving customer service
- Users at each facility have capability to log onto each facility's DHCP and schedule clinic visits
- Completed interactive, computer-assisted C&P exam training program for MI
- VISN 11 Web page available via Intranet
- Conducted briefings with veterans groups and congressional offices
- Partnered with VBA to identify non-VHA users from C&P files
- Contracted with a marketing specialist to provide service at VAMC Indianapolis with terms of specific network actions
- Developed twelve network-wide clinical guidelines for implementation
- VAMCs Ann Arbor and Indianapolis involved in pilot performance monitoring benchmarking projects with private sector
- Provided DHCP access to network Clinical Manager and HSS staff
- All seven network facilities and related OPCs completed the full JCAHO hospital based survey cycle
- VAMC Ann Arbor achieved accreditation from the American College of Radiation Oncology
- Six facilities calculate FIM scores for rehabilitation services
- Battle Creek uses GAF measure in Psychiatry Service
- All seven VAMCs have instituted some form of wellness programs (e.g. Smoking Cessation, Nutrition Education)

- Initiated discussion with VBA regarding community case finding and resource identification
- Appointed network staff member to coordinate assessment of current homeless resources
- Negotiated and signed all academic affiliation agreements involving medical schools
- Network met residency allocation goals for AY98 and is already positioned to achieve AY99/00 goals in advance
- Network Health Exchange is being used
- Reached network goal of customer service training of 4 hours per employee
- VISN 11 scored higher than the VHA national average in six out of seven subject areas in the national VA Quality Improvement Survey
- Completed computer training in DSS, CRISP, word processing and VISTA data base utilization
- Established employee “help desks” via mailman to share information and ask questions
- Network Director conducted quarterly conference calls with network facility union presidents and met with them individually during site visits
- Labor representatives are members of MAC and Strategic Planning Board
- Comprehensive informal resolution training has occurred at NIHCS and Indianapolis
- Network activated all facilities into Consolidated Mail-Out Pharmacy at Hines IL

***Information as of December 12, 1997. The financial and workload information presented in this package is currently under review for use in budget justifications submitted to Congress.***

**BUDGETARY DATA SET (VISN 11)** **Table B-1**

| | 1997 Base | 1998 Tactical | 1999 Strategic | 2000 Strategic | 2001 Target | 2002 Target | 2003 Target |
|---|---|---|---|---|---|---|---|
| **1. Financial ($'s in thousands):** | | | | | | | |
| a. Medical Care, Sources of Funding: | | | | | | | |
| VERA Allocation for Medical Care | $657,072 | $629,528 | $627,784 | $627,784 | $627,784 | $627,784 | $627,784 |
| MCCR Collection | $22,654 | $25,000 | $25,000 | $25,000 | $25,000 | $25,000 | $25,000 |
| Medicare Reimbursement | $0 | $0 | $11,000 | $13,750 | $17,188 | $23,250 | $27,900 |
| Tricare Collection | $0 | $750 | $1,000 | $1,250 | $1,500 | $2,000 | $2,200 |
| Other Sharing/Reimbursements | $1,645 | $3,000 | $6,000 | $9,000 | $15,000 | $19,500 | $21,840 |
| Planned Unobligated Balances [Non-Add] | | | | | | | |
| **Total = Allocation + Revenues** | $681,371 | $658,278 | $670,784 | $676,784 | $686,472 | $697,534 | $704,724 |
| b. Percent Revenues to Allocation + Revenues | 3.57% | 4.37% | 6.41% | 7.24% | 8.55% | 10.00% | 10.92% |
| c. Distribution of Funding by selected activities: | | | | | | | |
| Acute Hospital Care | $353,147 | $335,490 | $319,480 | $292,750 | | | |
| Outpatient Care | $244,808 | $257,048 | $267,320 | $292,750 | | | |
| Long-Term Care | $60,762 | $61,977 | $65,200 | $66,504 | | | |
| Total | $658,717 | $654,515 | $652,000 | $652,004 | | | |
| **2. Federal Employment:** | | | | | | | |
| Average Employment (FTE), Total | 8,456 | 8,160 | 7,915 | 7,717 | | | |
| **3. Unique Patient Users (PRPs): [Unduplicated at the National Level]** | | | | | | | |
| a. Total Unique Patient Users (PRPs) | 131,662 | 136,928 | 142,406 | 147,390 | 152,548 | 157,888 | 163,414 |
| Percent Increase/Decrease from 1997 Base | | 4.00% | 8.16% | 11.95% | 15.86% | 19.92% | 24.12% |
| b. Distribution of PRPs by Eligibility Category: | | | | | | | |
| Category A | 110,775 | 118,775 | 126,775 | 134,775 | | | |
| Category C | 6,747 | 6,612 | 6,480 | 6,350 | | | |
| Non-Veteran Users | 14,140 | 11,541 | 9,151 | 6,265 | | | |
| Total | 131,662 | 136,928 | 142,406 | 147,390 | | | |
| c. Distribution of PRPs by VERA Patient Groups: | | | | | | | |
| Special Care Unique Patient Users | 7,900 | 8,097 | 8,300 | 8,507 | | | |
| Basic Care Unique Patient Users | 123,762 | 128,831 | 134,106 | 138,883 | | | |
| Total | 131,662 | 136,928 | 142,406 | 147,390 | | | |
| **4. Workload Episodes:** | | | | | | | |
| a. Outpatient Visits (Staff & Fee) | 1,207,882 | 1,238,281 | 1,258,059 | 1,277,110 | | | |
| b. Acute Hospital Care: | | | | | | | |
| Acute Hospital Beds | 1,423 | 1,380 | 1,339 | 1,312 | | | |
| Acute Hospital ADC | 1,332 | 1,173 | 1,138 | 1,115 | | | |
| Acute Inpatients Treated | 30,401 | 27,361 | 24,625 | 22,162 | | | |
| c. Long-Term Care: | | | | | | | |
| Long-Term Beds | 746 | 806 | 866 | 926 | | | |
| Long-Term ADC | 696 | 766 | 823 | 880 | | | |
| Long-Term Inpatients Treated | 2,036 | 2,097 | 2,160 | 2,225 | | | |
| **5. Number of Facilities:** | | | | | | | |
| VA Hospitals | 8 | 8 | 8 | 8 | | | |
| VA Nursing Home Care Units | 8 | 8 | 8 | 8 | | | |
| VA Domiciliaries | 0 | 0 | 0 | 0 | | | |
| Outpatient Clinics: | | | | | | | |
| Hospital Based, Independent & Mobile | 8 | 8 | 8 | 8 | | | |
| CBOCs, CBCs, Satellite & Outreach | 6 | 12 | 14 | 17 | | | |
| **6. Financial Measures (Medical Care):** | | | | | | | |
| a. Obligations Per Unique User Analysis (30% network goal): | | | | | | | |
| Obligations Per Unique User | $5,175 | $4,807 | $4,710 | $4,592 | $4,500 | $4,418 | $4,313 |
| Percent Change from 1997 Base | | -7.11% | -8.99% | -11.27% | -13.04% | -14.63% | -16.66% |
| Assumed Portion Current Services | | 3.75% | 7.63% | 11.63% | 15.45% | 19.92% | 24.28% |
| Percent Change Net of Current Services | | -10.86% | -16.62% | -22.90% | -28.49% | -34.55% | -40.94% |
| b. % Change in Unique Patient Users from 1997 base, from line 2a. above (20% network goal) | | 4.00% | 8.16% | 11.95% | 15.86% | 19.92% | 24.12% |
| c. % Revenues to Allocation + Revenues, from line 1b. above (10% network goal) | 3.57% | 4.37% | 6.41% | 7.24% | 8.55% | 10.00% | 10.92% |
| d. % of Acute Hosp.$s to Tot.of Acute $s + OP $s | 59.06% | 56.62% | 54.44% | 50.00% | | | |
| e. Outpatient Visits Per Unique User | 9.17 | 9.04 | 8.83 | 8.66 | | | |
| f. Med. Care Capital Obligations Per Unique User | $215 | $167 | $161 | $155 | | | |

# VA GREAT LAKES HEALTHCARE SYSTEM (NETWORK 12)
PLAN SUMMARY

## VISN OVERVIEW

The network area covers the far northern portion of Illinois, most of Wisconsin, the Upper Peninsula of Michigan, and a small portion of northwestern Indiana. Six of the eight major medical care sites are highly affiliated with medical schools and other university programs. This network's catchment area has a large number of low income Category A veterans who tend to increase the acuity of the case mix. The estimated veteran population for FY97 was 1,255,500.

## PLAN HIGHLIGHTS

| | |
|---|---|
| ***Quality*** | • Implement clinical practice guidelines and report data on the Ischemic Heart Disease and the Major Depressive Disorders<br>• Identify and implement 19 additional clinical practice guidelines by the end of FY2000<br>• High volume testing will be analyzed to ensure that physician ordering patterns are reasonable and prudent in relation to outcome and quality of patient care<br>• The network is to become a data-driven organization in which quality improvement is based on sound data<br>• The Quality Management Task Force will work with the different sites to develop a plan for ensuring timeliness of access to services<br>• Building on the work already accomplished in the area of credentialing and privileging, the Quality Management Task Force will review the feasibility of the stated performance goals<br>• The progression of information technology to allow the use of telemedicine as a viable means to provide quality patient care is an area we consider important in our future<br>• In conjunction with the National Formulary Committee, begin to develop a means to examine clinical outcomes of use of specific pharmaceutical agents or drug classes within our network, particularly as they relate to improved patient functioning and decreased hospitalization rates |

| | |
|---|---|
| ***Performance Measurement System*** | • Identify and implement patient-focused outcome measures for the integration<br>• Identify additional VACHCS services to be consolidated under a single chief<br>• Measure integration patient-focused outcome measures and implement actions for improvement where the results indicate a need for improvements in quality or efficiency<br>• Increase percentage of surgery and invasive diagnostic procedures performed in an ambulatory care setting to 80 percent<br>• Increase the number of non-physician providers<br>• Improve laboratory productivity by 10 percent<br>• Compare outcome measures against private sector benchmarks<br>• Reduce to 50 percent the percentage of Class III, VI and Continuing Care (P1 - #19) dental patients seen at each facility<br>• Continue to reduce the number of patients receiving fee basis dental care<br>• Increase utilization of CMOP by 5 percent<br>• Expand substance abuse treatment capability to 100 percent of our CBOCs.<br>• Implement cross-matching database to better identify patients with insurance coverage<br>• Increase the percentage of patients enrolled in primary care from 85 percent to 90 percent<br>• Identify benchmarks for the use of the Addiction Severity Index (ASI) to assure consistent application of the instrument |
| ***Customer Service*** | • Implement 24 hour-a-day customer friendly telephone triage network-wide<br>• Monitor waiting times for appointments; implement any required corrective measures<br>• Complete enhanced use initiative underway at Chicago (WS) to construct parking facilities<br>• Upgrade/expand ambulatory care areas at VACHCS Lakeside and Westside, Tomah and Hines to address patient privacy, comfort and satisfaction concerns |
| ***Primary Care/Case Management*** | • Expand patient case management in primary care, surgical services, substance abuse, and long term care<br>• Complete Ambulatory Care Addition at Milwaukee and Ambulatory Care Center at Hines, to increase/upgrade outpatient capacity to accommodate workload shifted from inpatient to outpatient setting<br>• Construct/upgrade ambulatory surgery facilities at VACHCS Lakeside and Westside, Iron Mountain and Milwaukee and increase percent of surgery and invasive diagnostic procedures performed in ambulatory care setting |

| | |
|---|---|
| ***Special Emphasis Programs and Six Disabling Conditions*** | • Improve access for blind veterans by increasing outpatient services, reducing inpatient length of stays, and ensuring that the educational curriculum meets patient needs<br>• Expand the homeless program and increase coordination between VA and non-VA resources<br>• Expand community-based treatment sites for Post Traumatic Stress Disorder<br>• Share information among our Mental Health Council and Vet Center programs to identify any gaps in service<br>• Improve access for geriatric and frail elderly veterans |
| ***Community Based Outpatient Clinics (CBOCs)*** | <u>FY98 Locations</u><br>Chicago Heights, IL<br>Union Grove, WI<br><br><u>FY99 Locations</u><br>Aurora, IL,<br>Elgin, IL<br>LaSalle County, IL<br>Rhinelander, WI<br>Wausau, WI<br><br><u>FY00 Locations</u><br>Baraboo, WI<br>Beaver Dam, WI<br>Chicago, IL (mid-south)<br>Chicago, IL (northwest)<br>Janesville, WI<br>Marinette, WI<br>Oak Lawn, IL<br>Oswego, IL |
| ***Community Based Care Initiatives*** | • Expand community-based programs for adult day healthcare<br>• Expand the home care program either through VA or community arrangements |
| ***Improving Clinical and Administrative Information Systems*** | • Implement the computerized medical record<br>• Provide educational programs for clinicians and support staff on clinical informatics and the use of computer technology<br>• Expand teleradiology capabilities network-wide |
| ***Communication*** | • Refine needs assessment of stakeholder groupings (patients, employees, politicians, community, etc.) and continue to proactively inform, educate, and include them in decision making as appropriate<br>• Develop ongoing relationship with media representatives<br>• Identify and establish working relationship with network's federal and state legislators |
| ***Education*** | • Establish a uniform process to measure trainee satisfaction, and implement solutions for at least 10 of the issues identified for improvement<br>• Conduct education for quality managers, top management at each facility, and VISN staff on JCAHO surveys to prepare for FY 2000 survey<br>• Implement outcome measures aimed at improving patient satisfaction, CPAP compliance, and patient education<br>• Conduct an educational program at each facility on the VISN 12 scope of eligibility and dental care policy and uniform dental consult form<br>• Develop a definition of VA case management and an educational curriculum at the national level for those healthcare providers functioning in a case manager role<br>• Increase the number of QI and customer service education hours offered to our employees |

| | |
|---|---|
| ***Research*** | • Ensure that research programs are responsive to the needs of VA and that the research infrastructure is sound<br>• Research Service at Hines is conducting a project which, when completed, will give definitive answers to questions related to the cost effectiveness and customer satisfaction resulting from CMOP operations<br>• Implement a health services research and development (HSR&D) study of barriers to access and use of services<br>• Institute trial multi-site research endeavors<br>• Plan many research initiatives involving special populations |
| ***Sharing Agreements*** | • Increase the number and the return from sharing agreements, by implementing agreements with TriCare and others |
| ***Contracting Services*** | • Evaluate and use, as appropriate, consolidated fee basis contract for women's healthcare, psychiatry, readjustment, specialty clinics, visiting nurses, home health services, and compensation and pension exams |
| ***Managing Human Resources*** | • Increase the number of non-physician providers to 164 by the end of FY2000<br>• Identify overhead costs associated with mandatory and non-mandatory training<br>• Provide interpersonal skills training to enable staff to focus on the problem, issue, or behavior and not on the individual<br>• Reward staff for compliments received from patients and others<br>• Under the Southern Tier consolidations, all HR staff and functions are accomplished at the Hines Office, including staffing, classification, benefits and records, OPF maintenance, and employee and labor relations functions<br>• Implementation of the HR consolidation is expected to result in an overall HR staff reduction of about 20 percent |
| ***Facility and/or Service Consolidations*** | • Further integrate the Lakeside and West Side divisions of the VA Chicago Health Care System by fully integrating the initial 16 services consolidated under a single chief, operationalizing a Dean's Committee, and identifying additional services to be consolidated under a single chief<br>• Implement efficiencies in the Prosthetics and Orthotics Service by consolidating orthotic services and by implementing the Automated Fabrication of Mobility Aids system network-wide |
| ***Emergency Preparedness*** | • Review and revise Emergency Medical Preparedness Plan and ensure emergency preparedness readiness by conducting training sessions on comprehensive emergency management (mitigation, preparedness, response, and recovery) to include the incident command system |

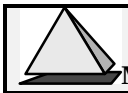

## NETWORK STRATEGIC PLAN SUMMARY

**Mission Goal:** Provide the Taxpayer Maximum Return on Investment

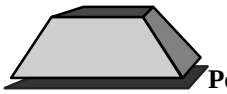
| Operating Strategies | Performance Goals |
|---|---|
| **Reduce Bed Days of Care(BDOC)/1000 Users** | **'98:** Reduce an additional 640 BDOC/1000 users<br>**'99:** Reduce BDOC/1000 users from 1,493 to 1,161<br>**'00:** Reduce BDOC/1000 users from 1,161 to 889 |
| **Consolidate and Downsize Inpatient Services, Shifting Care to the Outpatient Setting** | **'98:** Close an additional 213 acute hospital beds<br>**'99:** Reduce the number of acute hospital beds from 750 to 600<br>**'00:** Reduce the number of acute hospital beds from 600 to 550 |

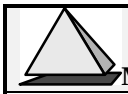
**Mission Goal:** Honor, Compensate and Care for Veterans in Recognition of Their Service

| Operating Strategies | Performance Goals |
|---|---|
| **Enroll all Eligible Patients in Primary Care** | **'98:** Increase the percentage of patients enrolled in primary care from 85 percent to 90 percent<br>**'99:** Increase the percentage of patients enrolled in primary care from 90 percent to 95 percent<br>**'00:** Increase the percentage of patients enrolled in primary care from 95 percent to 100 percent |
| **Implement Outcomes Focused Efficiencies in Mental Health Special Emphasis Programs** | **'98:** Implement comprehensive utilization management in all mental health programs and further refine clinical guidelines for Major Depressive Disorders to meet needs of VISN patients<br>**'99:** Identify and develop benchmarks for GAF, MDD, and UM outcome measures initiated in FY 98<br>**'00:** Assess facility programs for special emphasis program outcomes using benchmarks identified in FY98 |

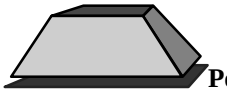


**Mission Goal:** Create and Maintain a High Performing Workforce to Serve Veterans

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Increase the Number of Quality Improvement and Customer Service Education Hours Offered to Employees** | **'98:** Increase employee education for QI or customer service to 10 hours/year/employee<br>**'99:** Increase employee education for QI or customer service to 20 hours/year/employee<br>**'00:** Increase employee education for QI or customer service to 30 hours/year/employee |
| **Ensure the Implementation of Education and Training Programs that Support the Network's Vision and the "New VA"** | **'98:** Implement at least two new VISN-wide educational programs that support the network's vision and the "new VA"<br>**'99:** Implement at least two additional VISN-wide educational programs that support the network's vision and the "new VA"<br>**'00:** Implement at least two additional VISN-wide educational programs that support the network's vision and the "new VA" |



**Mission Goal:** Provide "One VA" World Class Customer Service

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Measure, Analyze, and Address Patient Satisfaction Concerns** | **'98:** Address concerns identified from customer feedback surveys by establishing a performance improvement group at each facility where data indicates a need for improvement<br>**'99:** Show improvement in the national survey results for all categories addressed by the performance improvement groups<br>**'00:** Establish an integrated customer service program |
| **Improve Continuity of Care Among Sites** | **'98:** Ensure that 90 percent of enrolled patients assigned to primary care are enrolled at only one facility, improve feedback mechanisms to primary care providers, and increase use of telemedicine<br>**'99:** Ensure that 95 percent of enrolled patients assigned to primary care are enrolled at only one facility, and implement necessary adjustment to the substance abuse continuum of care and staffing capabilities<br>**'00:** Ensure that 100 percent of enrolled patients assigned to primary care are enrolled at only one facility |

## 1997 SELECTED ACCOMPLISHMENTS

- Placed VBA compensation and pension claims employees in the West Side Division of the Chicago Health Care System decreasing the veteran no-show rate for examinations from 10 percent to 3 percent, increased timeliness, drastically reduced the number of exams that were insufficient or inadequate, and increased face-to-face interaction among employees of both organizations with each other and with veterans
- Established joint procedures among VHA, VBA, and the Great Lakes Naval Training Center to provide pre-discharge C&P information and processing for persons soon to be discharged
- Consolidated home oxygen and durable medical equipment of four medical sites into one unique standardized contract
- Consolidated contracting and purchasing under the new Acquisition Center
- Converted general inpatient psychiatry and substance abuse beds to residential care
- Increased number and return from sharing agreements
- Reduced BDOC/1000 users from 2,882 to 2,081 between 8/96 and 8/97, and closed 1,115 operating beds during FY97
- Began integration of Lakeside and West Side Medical Centers to become the VA Chicago Health Care System
- Established a new community based outpatient clinic in Hancock, MI, and developed and submitted proposals for 7 additional locations
- Established numerous primary care teams at the 8 major medical sites
- Several sites are using sub-specialty and specialty physicians, in addition to nurse practitioners and physician assistants, to provide primary care—depending on the patient's needs
- Completed an education plan for implementing educational priorities network-wide
- Began implementing VA's "Customer Service: An Integrated Approach" at all sites
- Completed a business plan for implementing efficiencies in substance abuse services
- Employees are rewarded for working together in teams (for example, performance ratings, cash awards, certificates, and public recognition)
- This year, we have taken a big step forward in defining specific performance goals linked to most of our operational strategies
- VACHCS' Quality Leadership Team established process action teams to address issues identified from the national VA consumer survey
- The seamless transfer of patients and exchange of staff between sites has produced a higher quality of service, delivered at the same or lower cost
- Our Quality Management Task Force has evaluated the benefits and drawbacks of a common credentialing and privileging system for physicians in our network. A single credentialing and privileging system was adopted
- Nurse practitioners, medical residents, and attendings have also received formal education and training on screening patients with insensitive feet. Once identified, these patients are referred to Physical Therapy for entry into our PACT Program
- Award of a network-wide contract for commercial testing
- Institution of a courier system to transport specimens within our network
- Migration of clinical testing to two core laboratories and identified specialty laboratories
- Establishment of an organizational structure that enhanced resource management
- Development of a telecommunication linkage between our eight major care sites
- Establishment of a network-wide standardization program for consumable supplies

- VACHCS regularly assesses waiting and appointment times and follows up on issues that need improvement
- Standardized definition and performance expectations for telephone triage
- Standardized definition and performance expectations for telephone care
- Network improved in 7 out of 9 inpatient survey categories in the 1997 National Survey Report of Recently Discharged Inpatients
- Iron Mountain has begun implementation of the computerized medical record/computerized patient record system (CPRS), and its staff is able to access current patient information through VISTA
- VACHCS increased space available for primary care through conversion of consolidated administrative offices
- North Chicago has developed provider profiling software that provides monthly provider specific reports that reflect workload and costs associated with the patients enrolled
- Supported Acquisition Center training for individual site employees
- VACHCS conducts regular residency evaluations to determine specific program strengths and weaknesses, e.g., availability of medications and supplies, and information resources management. Evaluation results are conveyed to appropriate VACHCS staff for follow-up
- Provided common training by the U.S. Army on career transition to assist sites with developing the career transition programs necessitated by reductions in force
- Cost avoidance savings of $2 million in Pathology and Laboratory Medicine Service

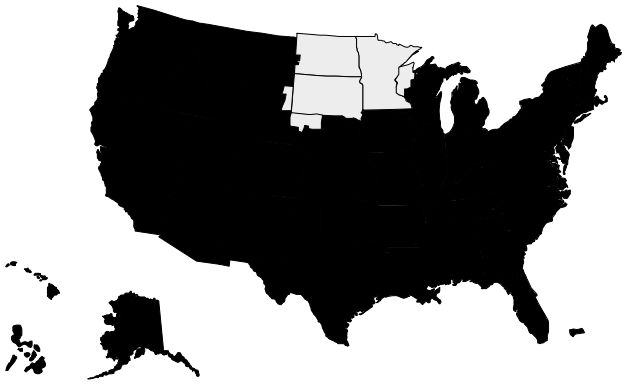
***Information as of December 12, 1997. The financial and workload information presented in this package is currently under review for use in budget justifications submitted to Congress.***

**BUDGETARY DATA SET (VISN 12)** **Table B-1**

| | 1997 Base | 1998 Tactical | 1999 Strategic | 2000 Strategic | 2001 Target | 2002 Target | 2003 Target |
|---|---|---|---|---|---|---|---|
| **1. Financial ($'s in thousands):** | | | | | | | |
| a. Medical Care, Sources of Funding: | | | | | | | |
| VERA Allocation for Medical Care | $827,931 | $789,397 | $769,635 | $769,635 | $769,635 | $769,635 | $769,635 |
| MCCR Collection [See Note] | $0 | $35,112 | $39,941 | $44,776 | $49,358 | $53,931 | $54,000 |
| Medicare Reimbursement | | | | | $12,300 | $28,965 | $30,000 |
| Tricare Collection | $0 | $250 | $500 | $1,000 | $1,500 | $2,500 | $2,500 |
| Other Sharing/Reimbursements | $4,099 | $4,400 | $5,400 | $6,400 | $7,400 | $8,400 | $9,400 |
| Planned Unobligated Balances | | ($17,000) | ($7,000) | ($7,000) | ($7,400) | ($7,900) | ($8,400) |
| **Total = Allocation + Revenues** | $832,030 | $812,159 | $808,476 | $814,811 | $832,793 | $855,531 | $857,135 |
| b. Percent Revenues to Allocation + Revenues | 0.49% | 4.90% | 5.67% | 6.40% | 8.47% | 10.96% | 11.19% |
| c. Distribution of Funding by selected activities: | | | | | | | |
| Acute Hospital Care | $218,453 | $203,789 | $189,125 | $174,460 | | | |
| Outpatient Care | $230,291 | $234,889 | $238,889 | $243,187 | | | |
| Long-Term Care | $109,981 | $110,327 | $110,673 | $111,020 | | | |
| Total | $558,725 | $549,005 | $538,687 | $528,667 | | | |
| **2. Federal Employment:** | | | | | | | |
| Average Employment (FTE), Total | 10,595 | 9,800 | 9,500 | 9,400 | | | |
| **3. Unique Patient Users (PRPs): [Unduplicated at the National Level]** | | | | | | | |
| a. Total Unique Patient Users (PRPs) | 151,532 | 160,624 | 168,655 | 175,400 | 179,000 | 181,832 | 182,000 |
| Percent Increase/Decrease from 1997 Base | | 6.00% | 11.30% | 15.75% | 18.13% | 20.00% | 20.11% |
| b. Distribution of PRPs by Eligibility Category: | | | | | | | |
| Category A | 128,499 | 136,709 | 143,519 | 148,739 | | | |
| Category C | 18,184 | 18,675 | 19,539 | 20,648 | | | |
| Non-Veteran Users | 4,849 | 5,240 | 5,597 | 6,013 | | | |
| Total | 151,532 | 160,624 | 168,655 | 175,400 | | | |
| c. Distribution of PRPs by VERA Patient Groups: | | | | | | | |
| Special Care Unique Patient Users | 8,789 | 9,216 | 9,582 | 9,773 | | | |
| Basic Care Unique Patient Users | 142,743 | 151,408 | 159,073 | 165,627 | | | |
| Total | 151,532 | 160,624 | 168,655 | 175,400 | | | |
| **4. Workload Episodes:** | | | | | | | |
| a. Outpatient Visits (Staff & Fee) | 1,761,090 | 1,937,199 | 2,130,919 | 2,340,079 | | | |
| b. Acute Hospital Care: | | | | | | | |
| Acute Hospital Beds | 963 | 750 | 600 | 550 | | | |
| Acute Hospital ADC | 544 | 530 | 510 | 465 | | | |
| Acute Inpatients Treated | 26,202 | 27,365 | 28,333 | 28,007 | | | |
| c. Long-Term Care: | | | | | | | |
| Long-Term Beds | 1,301 | 1,525 | 1,550 | 1,575 | | | |
| Long-Term ADC | 2,566 | 2,750 | 2,775 | 2,800 | | | |
| Long-Term Inpatients Treated | 3,432 | 3,800 | 4,000 | 4,200 | | | |
| **5. Number of Facilities:** | | | | | | | |
| VA Hospitals | 8 | 8 | 8 | 8 | | | |
| VA Nursing Home Care Units | 5 | 5 | 5 | 5 | | | |
| VA Domiciliaries | 2 | 2 | 2 | 2 | | | |
| Outpatient Clinics: | | | | | | | |
| Hospital Based, Independent & Mobile | 0 | 0 | 0 | 0 | | | |
| CBOCs, CBCs, Satellite & Outreach | 13 | 15 | 20 | 28 | | | |
| **6. Financial Measures (Medical Care):** | | | | | | | |
| a. Obligations Per Unique User Analysis (30% network goal): | | | | | | | |
| Obligations Per Unique User | $5,491 | $5,056 | $4,794 | $4,645 | $4,652 | $4,705 | $4,710 |
| Percent Change from 1997 Base | | -7.92% | -12.69% | -15.41% | -15.28% | -14.31% | -14.22% |
| Assumed Portion Current Services | | 3.75% | 7.63% | 11.63% | 15.45% | 19.92% | 24.28% |
| Percent Change Net of Current Services | | -11.67% | -20.32% | -27.04% | -30.73% | -34.23% | -38.50% |
| b. % Change in Unique Patient Users from 1997 base, from line 2a. above (20% network goal) | | 6.00% | 11.30% | 15.75% | 18.13% | 20.00% | 20.11% |
| c. % Revenues to Allocation + Revenues, from line 1b. above (10% network goal) | 0.49% | 4.90% | 5.67% | 6.40% | 8.47% | 10.96% | 11.19% |
| d. % of Acute Hosp.$s to Tot.of Acute $s + OP $s | 48.68% | 46.46% | 44.19% | 41.77% | | | |
| e. Outpatient Visits Per Unique User | 11.62 | 12.06 | 12.63 | 13.34 | | | |
| f. Med. Care Capital Obligations Per Unique User | $409 | $290 | $246 | $233 | | | |

# VA UPPER MIDWEST NETWORK (NETWORK 13)
PLAN SUMMARY

## VISN OVERVIEW



A large geographic area encompassing all or portions of seven states: Minnesota, North Dakota, South Dakota, northwestern Iowa, northwestern Nebraska, western Wisconsin and eastern Wyoming. Spans 700 miles of urban, rural and frontier settings. The estimated FY97 veteran population is 656,900. In 1997, 95.6 percent of veterans served were category A. In 1997, network medical centers provided a seven percent increase in outpatient visits over 1996. The number of hospital discharges decreased 26 percent, reflecting the network's focus to shift to an outpatient setting

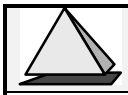
## PLAN HIGHLIGHTS

| | |
|---|---|
| ***Quality*** | • Implement a DSS-based provider profiling system at each medical center and supply quarterly feedback<br>• Implement valid functional assessment tools for all patient service lines<br>• Initiate geriatrics and extended care performance improvement measures through staff training and implementing performance measures<br>• Increase the PI score from 39 percent in FY96 to 95 percent in FY00<br>• Ensure that 50 percent of targeted veteran population receive care at new CBOCs in first 12 months of operation<br>• Increase to 80 percent the portion of Management Assistance Council members who report improved satisfaction with the Council's operations |
| ***Customer Service*** | • Develop a Network Customer Service/Consumer Affairs Plan<br>• Conduct patient satisfaction surveys more frequently than annually<br>• Obtain funding for inpatient environmental improvement project at Fargo to make much needed HVAC, patient privacy and life safety improvements<br>• Create more convenient access for outpatients coming to radiation therapy at Minneapolis<br>• Renovate inpatient space at Sioux Falls to improve patient privacy and increase patient satisfaction |

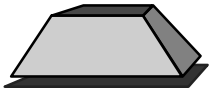
| | |
|---|---|
| ***Primary Care/Case Management*** | • Refine implementation of case management and evaluation based on continuity of care, patient satisfaction, readmission rates and LOS<br>• Evaluate and recommend improvements in care coordination<br>• Renovate/expand ambulatory care space to improve efficiency of existing clinics at Fargo and Sioux Falls<br>• Expand primary care clinic space at St. Cloud and Black Hills North |
| ***Special Emphasis Programs and Six Disabling Conditions*** | • Develop or modify existing tools to forecast needs for next 3-5 years in Geriatrics and Long Term Care<br>• Establish VISN 13 Homeless Veteran Advisory Council (VA and community stakeholders)<br>• Increase portion of service connected veterans for PTSD who use VA mental health services to 85 percent in FY98<br>• Continue PACT teams; Gulf War Vet Programs; VIST programs; SCI/dysfunction programs; and operate women veteran clinics at each VAMC<br>• Identify training needs in conjunction with vet center staff and collocate primary care activity in vet center space<br>• Evaluate mental health patients at least once in FY98 using Global Assessment of Functioning (GAF)<br>• Standardize policy development and provide technical guidance network-wide for prosthetics and orthotics |
| ***Community Based Outpatient Clinics (CBOCs)*** | • Mankato, Hibbing, Fergus Falls, St. Paul, Brainerd, MN, Bismarck, ND, Western Wisconsin (with VISN12) and Pierre, SD ('98)<br>• Sioux City, IA and Minot, ND ('99)<br>• Worthington, MN ('00) |
| ***Community Based Care Initiatives*** | • Support an active Respite Care Program by maintaining 40 or more respite admissions/year and increasing respite admissions by one percent by FY00<br>• Incorporate core benefits package into alternative care program (in lieu of institutionalization) |
| ***Service Lines*** | • Establish patient service lines: Primary Care; Specialty Care; Mental and Behavioral Health Care and Extended Care |
| ***Improving Clinical and Administrative Information Systems*** | • Complete implementation of DSS and capture 100 percent billable workload by FY00<br>• Coordinate network information technology and information systems through a network Chief Information Officer<br>• Implement a Network Business Office<br>• Implement TIP at all five medical centers<br>• Implement computer systems to support exchange of uniform patient and business information<br>• Implement video teleconferencing equipment at five medical centers and network office<br>• Support development of telemedicine between sites and with other business partners<br>• Develop an implementation plan for integration of the electronic medical record and business information across all medical centers |

| | |
|---|---|
| ***Communication*** | • Hold Town Hall meetings with medical center employees; meet quarterly with Union representatives<br>• Develop an internal and external communications plan for employees and union presidents<br>• Educate veteran population on eligibility, entitlements, means test and other legislation |
| ***Education*** | • Coordinate educational activities across the network, and implement an Education Product Line to support the network's integrated delivery system<br>• Ensure that 75 percent of employees will have completed training on cultural changes within the network and VA system by the end of FY98<br>• Become a Mental Illness Research Education Center (MIREC) and a HSR&D field station |
| ***Research*** | • Implement a Research Product Line to coordinate research across the network<br>• Increase network's funding of research projects (increase by 5 percent) |
| ***Sharing Agreements*** | • Partner with community for high tech equipment<br>• Expand/enhance DOD/community sharing agreements and generate $.5M (FY98); $2.8M (FY99) and $3.7 M (FY00)<br>• Increase TriCare provider outpatient visits by 100 percent in FY98 and by 50 percent in FY99 and FY00 |
| ***Contracting Services*** | • Utilize National Acquisition Center contracts for drugs and pharmaceuticals and other sources for standardized items, especially for medical/surgical supplies<br>• Utilize existing contracts for IV supplies, chemistry lab reagents, J&J Incentive BPA agreement and others<br>• Sell Network 13 Claims Management Center billing and collection services for MCCR and TriCare to other VISNs |
| ***Managing Human Resources*** | • Develop a process to provide mandatory employee education<br>• Examine affiliations with allied health affiliates and implement improvements based on results<br>• Recognize employee innovation and teamwork through local Incentive Awards Boards<br>• Identify outcome-based elements to include in network employee performance rating system |
| ***Facility and/or Service Consolidations*** | • Consolidate services at St. Cloud and Minneapolis VAMCs. Implement integration of MCCR services within network. One MCCR manager will report to Fargo CFO<br>• Coordinate biomedical engineering activities across network while maintaining medical equipment through in-house staff<br>• Consolidate, integrate, centralize or eliminate functions where operational efficiencies are achievable<br>• Centralize purchasing and contracting activities under a Chief, A&MMS, at one site |
| ***Emergency Preparedness*** | • Develop a Network Disaster Readiness Plan<br>• Coordinate emergency preparedness efforts with neighboring networks |


## NETWORK STRATEGIC PLAN SUMMARY



**Mission Goal:** Provide Value to Veterans through Quality Health Care

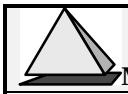
|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Document End of Life Planning** | **'98:** 80 percent of patients with terminal diagnoses or conditions will have documented plan<br>**'99:** 90 percent of patients will have end of life plan<br>**'00:** 95 percent will have documented end of life plan |
| **Implement Provider Profiling** | **'98:** Implement a DSS-based provider profiling system at each medical center<br>**'99:** Supply provider specific quarterly feedback on clinical guideline performance<br>**'00:** Establish quarterly team provider-profiling feedback |
| **Enhance the Risk Management Program** | **'98** Develop site-specific plans based on local assessment of risk for violence in the workplace<br>**'99** Conduct annual comprehensive risk management program evaluation at each site using FY98 data as a baseline to compare FY99 data<br>**'00** Establish risk management as a corporate function |

**Mission Goal:** Provide Value to Veterans through Improvement in Patient Functional Status

| Operating Strategies | Performance Goals |
|---|---|
| **Systematically Assess Functional Status to Help Patients Achieve and Sustain Optimal Functional Status** | **'98:** Evaluate current tools to assess status, develop educational plan and linkages to clinical guidelines and develop algorithms measuring changes and appropriate responses<br>**'99:** Implement recommendations<br>**'00:** Evaluate implementation and recommend changes based on findings |
| **Meet Performance Measures for Substance Abuse** | **'98:** 90 percent of substance abuse treatment programs veterans will have an initial ASI (within 12 mo.)<br>**'99:** 95 percent<br>**'00:** 98 percent |

**Mission Goal:** Provide Value to Veterans through Access to Health Care

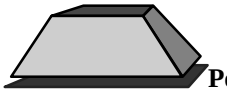
| Operating Strategies | Performance Goals |
|---|---|
| **Ensure Continuum of Long Term Care is Provided** | **'98:** Achieve 95 percent occupancy rate with response service of three days or less to patient service lines<br>**'99:** Increase turnover rate by one percent and evaluate 100 percent service-connected veterans for alternative placement<br>**'00:** Evaluate needs of patient population served and patient service lines to identify any needed program goal changes |
| **Increase Market Share** | **'98:** Develop communications plan to market veterans who received compensation from VA but haven't used VAMCs in last 3 years |



**Mission Goal:** Be a Leader in Research

**Operating Strategies**

**Pursue Research Strategy that Includes Basic, Clinical and Outcomes Research**

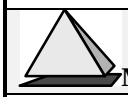


**Performance Goals**

**'98:** Form a Network 13 HSR&D service in order to develop appropriate clinical outcome measures and identify cost effective approaches to care

**'99:** Increase number of basic VA research projects by 5 percent

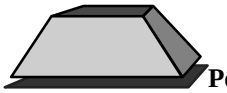
**'00:** Adopt a network-wide approach to VA participation in VA studies



**Mission Goal:** Provide Value to Veterans through Improved Customer Service

**Operating Strategies**

**Improve Customer Satisfaction**



**Performance Goals**

**'98:** Decrease average number of customer service standard problems reported by patients to meet national non-VA benchmarks

**'99:** Maintain or exceed national non-VA benchmarks for customer service standards

**'00:** Decrease average number of customer service standard problems per network patient to less than one problem out of 10 questions

**Mission Goal:** Be a Leader in Delivery of Veterans Benefits

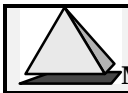
| Operating Strategies | Performance Goals |
|---|---|
| **Improve Processing of Compensation and Pension Exams** | **'00:** Achieve 98 percent of completed C&P requests reported by VBA as sufficient |
| **Improve Working Relationships Between Medical Centers and VBA Offices** | **'98:** Cross train VAMC and Regional Office staff on how the rating process works and how their roles contribute to the process<br>**'99:** Expand VBA staff at all medical centers including rating specialists |

**Mission Goal:** Be Accountable to Customers and Stakeholders

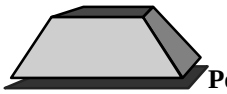
| Operating Strategies | Performance Goals |
|---|---|
| **Enhance Accountability to Veterans' Families** | **'98:** Incorporate shared-decision making with 50 percent of patients and families when present<br>**'99:** Create veteran and family service centers within network |
| **Enhance Relationships with Stakeholders** | **'98:** Institute the 360 degree performance assessment for senior managers utilizing feedback from stakeholders<br>**'99:** Institute 360 degree for other managers<br>**'00:** Evaluate effectiveness of communication vehicles |

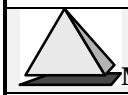
**Mission Goal:** Serve as a Leader in Education

| Operating Strategies | Performance Goals |
|---|---|
| **Examine Medical and Allied Health Educational Affiliations and Identify Future Directions** | **'98:** Survey MD house staff and other trainees to obtain baseline rating of their VA educational experience. Develop recommendations based on outcome<br>**'99:** Implement improvements based on recommendations |
| **Provide Education to Employees** | **'98:** Provide education to employees focused on customer service and the broad goals of stewardship<br>**'99:** Explore computer tracking of employee education and use of bar codes |

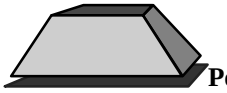


**Mission Goal:** Be an Employer of Choice

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Maintain a Safe, Healthy and Secure Workplace** | **'98:** Develop a health risk assessment tool for employees<br>**'99:** Develop ergonomics program based on a problem list and identify resources to fund in network<br>**'00:** Decrease lost time claim rate by 2 percent from the lowest lost time claim rate in last 3 years |
| **Create a Sense of Employee Ownership of the Service Delivery Among Employees** | **'98:** Ask each work unit at VAMCs to discuss network mission and how their work helps to meet the mission<br>**'99:** 75 percent of employees can describe how jobs contribute to mission of "new VA"<br>**'00:** 85 percent of employees can describe how jobs contribute to mission of "new VA" |



**Mission Goal:** Operate as a Comprehensive Integrated Delivery System

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Develop Network Managed Health Care Plan** | **'98:** Expand primary care enrollment to 85 percent of network veterans in FY98<br>**'99:** Expand to 95 percent<br>**'00:** Expand to 100 percent |
| **Develop Network Financial Management System** | **'98:** Use DSS for a facility level FY98 budget patient service line scenario<br>**'99:** Use DSS monthly output to focus on 30-20-10 targets and appropriate staffing mix for patient workload<br>**'00:** Use DSS for on-going, portable reporting for management decision-making at all levels on "real-time" |

**Mission Goal:** Provide Value to Veterans through Cost-effective Health Care

| Operating Strategies | Performance Goals |
|---|---|
| **Maximize Use of Outpatient Surgery** | **'98:** Increase total ambulatory surgery from 52 percent to 65 percent<br>**'99:** Increase to 70 percent<br>**'00:** Increase to 75 percent |
| **Redirect Resources from Inpatient to Outpatient** | **'98**: Close 116 operating beds (from 1458 to 1342); expand outpatient capacity by renovating existing inpatient space and decrease BDOC/1000 uniques from 2320 in FY96 to 1924<br>**'99:** Close 18 operating beds (from 1342 to1324); expand outpatient space by renovating existing inpatient space and decrease BDOC/1000 uniques and decrease BDOC to 1809<br>**'00:** Close 67 beds (from 1324 to1257); expand outpatient capacity by renovating existing inpatient space and decrease BDOC to 1645 |
| **Collect and Retain 3rd Party Payments through MCCR** | **'98:** Generate $19 M in alternative revenues<br>**'99:** Generate $20 M in alternative revenues<br>**'00:** Generate $21 M in alternative revenues |

**Mission Goal:** Be an Active Community and Federal Partner

| Operating Strategies | Performance Goals |
|---|---|
| **Ensure Readiness to Fulfill VA's Emergency Preparedness Role as Backup for DOD** | **'98**: Develop a Network Disaster Readiness Plan<br>**'99:** Provide disaster training for mental health teams<br>**'00:** Coordinate emergency preparedness efforts with neighboring networks |
| **Support Expanded Voluntary Efforts at VAMCs** | **'00:** Increase the number of youth volunteers in the network by 15 percent |

## 1997 SELECTED ACCOMPLISHMENTS

- VAMROC Fargo added two new affiliations for allied health training
- VAMC Minneapolis contracted with Arthritis Foundation where space and services exchanged for staff training, etc
- Clinical guidelines were implemented at all medical centers and outcomes measured to decrease variation and ensure one level of care, as much as possible
- Developed a UM action plan and published a network UM policy
- Developed a network-wide tobacco cessation plan
- Patient waiting times decreased for primary and specialty care appointments (three of five VAs offer waiting times (primary care) within 30 days
- Improved equity of access: all category A's are treated at VAMC Minneapolis
- Formed a Marketing Work Group to develop a marketing plan to increase Network's market share
- Medicare eligible veterans will participate in focus groups to determine if they would use VA under a VA/Medicare managed care plan or fee-for-service arrangement
- Grafton Primary Care Clinic improved access to primary care in ND area
- Developed a Research Service Line
- Director of VBARO in Minneapolis met quarterly with ELC to discuss strategies to improve C&P process
- Established a Network Public Affairs Liaison and developed a process to handle crisis situations at all medical centers
- Established a service line for education
- Network employees were recognized for their excellence and contribution in working towards creating an integrated delivery system
- Medical center specific DSS databases were merged to create the first network DSS database
- All networks connected with MS Exchange software
- ELC approved recommendations to establish and coordinate patient service line activities and outline steps for implementation
- 33 supervisory positions were eliminated by integration/consolidation at Hot Springs and Ft Meade
- VAMC St. Cloud integrated 27 services into eight functional/patient service lines
- All medical centers designated case management coordinators and case managers
- Developed a Network 13 Formulary as part of the National VA Formulary process
- Began treating TriCare patients in 4/97. Approximately 140 TriCare visits provided during 6 months of FY97 ($33,342 claims billed)
- VAMC Fargo conducted post hospitalization phone surveys of patients
- VAMC Minneapolis renovated area for patient and family center
- VA Black Hills Health Care system educated staff on customer service standards and established facility-specific monitors
- VAMROC Sioux Falls added orthopedic case managers and decreased walk-in appointments by 25 percent from FY96
- Completed implementation of Decision Support System (DSS) at each medical center**;** educated medical center staff on utilization and application of DSS
- Expanded telecommunication infrastructure and implemented video teleconferencing
- Began preparations to implement electronic medical record system
- Hired Chief Information Officer to coordinate information systems across all VISN sites

- Reviewed 80 possible functions to integrate/consolidate and implemented several integrations/consolidations network-wide
- Consolidated/centralized functions at VAMROC Fargo, VAMC Minneapolis and VAMROC Sioux Falls
- Redirected resources from inpatient to outpatient care at VA Black Hills, VAMROC Fargo, VAMC Minneapolis, Sioux Falls and VAMC St. Cloud
- Created staffing efficiencies by reviewing vacant positions for possible "non-fill", recruitment lag and buy-out capability
- Established a Medicare Readiness Task Force to prepare the network for a Medicare pilot
- Expanded and consolidated agreements at VA Black Hills Health Care System, VAMC Minneapolis, VAMROC Fargo, VAMC St. Cloud and VAMROC Sioux Falls with DOD/other providers to generate new revenues
- Medical centers in the network established work groups to review existing sharing agreements for exchange of services and identified new opportunities
- Encouraged membership in health care and professional organizations by identifying the various organizations available in the communities; publishing articles on community outreach and involvement in newsletters; surveying facilities staff for participation in health care and professional organizations
- Implemented a safety plan to ensure that all fire/safety, security and industrial hygiene goals are met; conducted annual work place evaluations at all medical centers in network
- Education programs were offered at each network medical center on adapting to new cultural changes within the network and VA system
- Formed Education Council to develop an integrated system to address the educational needs of staff, students and patients within the network
- Each medical center in the network addressed actions to meet customer service standards (e.g., customer service training, renovations of urgent care areas, provider identification cards, etc.)

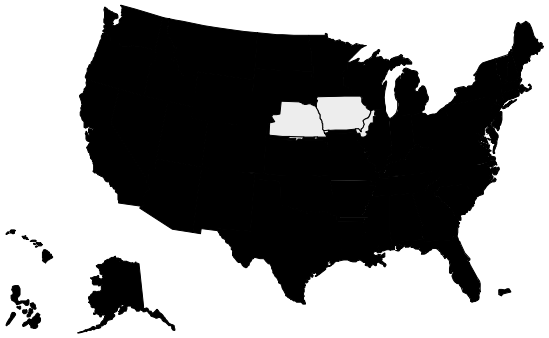
***Information as of December 12, 1997. The financial and workload information presented in this package is currently under review for use in budget justifications submitted to Congress.***

**BUDGETARY DATA SET (VISN 13)** **Table B-1**

| | 1997 Base | 1998 Tactical | 1999 Strategic | 2000 Strategic | 2001 Target | 2002 Target | 2003 |
|---|---|---|---|---|---|---|---|
| **1. Financial ($'s in thousands):** | | | | | | | |
| a. Medical Care, Sources of Funding: | | | | | | | |
| VERA Allocation for Medical Care | $425,635 | $412,036 | $412,036 | $412,036 | $412,036 | $412,036 | |
| MCCR Collection [See Note] | $0 | $18,979 | $19,643 | $22,767 | $32,282 | $39,524 | |
| Medicare Reimbursement | $0 | $0 | $2,000 | $3,000 | $4,600 | $9,200 | |
| Tricare Collection | $71 | $272 | $299 | $329 | $362 | $398 | |
| Other Sharing/Reimbursements | $2,366 | $3,076 | $4,000 | $4,400 | $4,840 | $5,324 | |
| Planned Unobligated Balances | ($4,003) | ($7,717) | ($5,026) | ($2,572) | ($812) | ($235) | |
| **Total = Allocation + Revenues** | $424,069 | $426,646 | $432,952 | $439,960 | $453,308 | $466,247 | $0 |
| b. Percent Revenues to Allocation + Revenues | 0.57% | 5.23% | 5.99% | 6.93% | 9.28% | 11.68% | |
| c. Distribution of Funding by selected activities: | | | | | | | |
| Acute Hospital Care | $133,063 | $115,824 | $102,279 | $89,070 | | | |
| Outpatient Care | $154,894 | $172,746 | $198,131 | $224,109 | | | |
| Long-Term Care | $75,351 | $76,755 | $79,464 | $81,134 | | | |
| Total | $363,308 | $365,325 | $379,874 | $394,313 | | | |
| **2. Federal Employment:** | | | | | | | |
| Average Employment (FTE), Total | 5,375 | 5,229 | 5,102 | 5,035 | | | |
| **3. Unique Patient Users (PRPs): [Unduplicated at the National Level]** | | | | | | | |
| a. Total Unique Patient Users (PRPs) | 85,456 | 88,618 | 91,897 | 95,297 | 99,585 | 104,066 | |
| Percent Increase/Decrease from 1997 Base | | 3.70% | 7.54% | 11.52% | 16.53% | 21.78% | -100.00% |
| b. Distribution of PRPs by Eligibility Category: | | | | | | | |
| Category A | 69,270 | 72,315 | 75,294 | 78,494 | | | |
| Category C | 3,157 | 3,274 | 3,574 | 3,774 | | | |
| Non-Veteran Users | 13,029 | 13,029 | 13,029 | 13,029 | | | |
| Total | 85,456 | 88,618 | 91,897 | 95,297 | | | |
| c. Distribution of PRPs by VERA Patient Groups: | | | | | | | |
| Special Care Unique Patient Users | 3,951 | 3,908 | 3,865 | 3,823 | | | |
| Basic Care Unique Patient Users | 81,505 | 84,710 | 88,032 | 91,474 | | | |
| Total | 85,456 | 88,618 | 91,897 | 95,297 | | | |
| **4. Workload Episodes:** | | | | | | | |
| a. Outpatient Visits (Staff & Fee) | 861,646 | 921,961 | 986,498 | 1,055,552 | | | |
| b. Acute Hospital Care: | | | | | | | |
| Acute Hospital Beds | 417 | 373 | 364 | 342 | | | |
| Acute Hospital ADC | 283 | 280 | 291 | 274 | | | |
| Acute Inpatients Treated | 21,936 | 21,686 | 21,000 | 20,500 | | | |
| c. Long-Term Care: | | | | | | | |
| Long-Term Beds | 2,095 | 2,077 | 2,068 | 2,023 | | | |
| Long-Term ADC | 1,831 | 1,870 | 1,861 | 1,821 | | | |
| Long-Term Inpatients Treated | 6,656 | 6,900 | 6,866 | 6,718 | | | |
| **5. Number of Facilities:** | | | | | | | |
| VA Hospitals | 6 | 6 | 6 | 6 | | | |
| VA Nursing Home Care Units | 5 | 5 | 5 | 5 | | | |
| VA Domiciliaries | 2 | 2 | 2 | 2 | | | |
| Outpatient Clinics: | | | | | | | |
| Hospital Based, Independent & Mobile | 6 | 6 | 6 | 6 | | | |
| CBOCs, CBCs, Satellite & Outreach | 13 | 22 | 24 | 25 | | | |
| **6. Financial Measures (Medical Care):** | | | | | | | |
| a. Obligations Per Unique User Analysis (30% network goal): | | | | | | | |
| Obligations Per Unique User | $4,962 | $4,814 | $4,711 | $4,617 | $4,552 | $4,480 | |
| Percent Change from 1997 Base | | -2.98% | -5.06% | -6.95% | -8.26% | -9.71% | |
| Assumed Portion Current Services | | 3.75% | 7.63% | 11.63% | 15.45% | 19.92% | 24.28% |
| Percent Change Net of Current Services | | -6.73% | -12.69% | -18.58% | -23.71% | -29.63% | |
| b. % Change in Unique Patient Users from 1997 base, from line 2a. above (20% network goal) | | 3.70% | 7.54% | 11.52% | 16.53% | 21.78% | -100.00% |
| c. % Revenues to Allocation + Revenues, from line 1b. above (10% network goal) | 0.57% | 5.23% | 5.99% | 6.93% | 9.28% | 11.68% | |
| d. % of Acute Hosp.$s to Tot.of Acute $s + OP $s | 46.21% | 40.14% | 34.05% | 28.44% | | | |
| e. Outpatient Visits Per Unique User | 10.08 | 10.40 | 10.73 | 11.08 | | | |
| f. Med. Care Capital Obligations Per Unique User | $234 | $262 | $252 | $243 | | | |

# VA CENTRAL PLAINS NETWORK (NETWORK 14)
PLAN SUMMARY

## VISN OVERVIEW



Network 14, centered in the Midwest U. S., covers most of Iowa, the eastern 2/3 of Nebraska, and a few of the border counties of Kansas, Missouri and Illinois. The majority of the veteran population resides in 6 metropolitan areas with the remainder sparsely spread throughout the rural areas. Although the veteran population in this network is shrinking, veterans aged 75 to 84 will increase by 20.9 percent over 1997 levels. This will require the Network to strengthen its healthcare services to meet the special demands of these elderly veterans. The estimated 1997 veteran population for this Network area is 475,400.

## PLAN HIGHLIGHTS

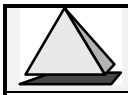
| | |
|---|---|
| ***Quality*** | • Implement clinical guidelines: pneumococcal immunization, influenza immunization, smoking cessation, major depressive disorder, management of bipolar disorder, diabetic foot care, SCI/SCD bowel management, pain management, emergency evaluation of chest pain, heart failure, total parenteral nutrition, diagnosis of deep venous thrombosis, and biochemical markers for diagnosis of myocardial infarction<br>• Implement the U.S. Preventive Services Task Force recommendations that apply to all veterans in the network<br>• Continue implementation of care pathways and development of an integrated database<br>• Continue development and implementation of provider profiling system |
| ***Performance Measurement System*** | • Install automated system to remind clinicians to follow the network-adopted health promotion and disease prevention guidelines and report results to the VHA National Center<br>• Implement performance reporting mechanisms to evaluate effectiveness of primary care. |
| ***Customer Service*** | • All facility Directors will continue an extensive program of customer feedback, events, forums, town halls, employee communications, process re-engineering, quality improvement, and veteran outreach<br>• Conducted a comprehensive customer service training program for key planning staff of each of the six medical centers<br>• Continue phasing in telephone triage Network-wide<br>• Renovate wards for patient privacy |

| | |
|---|---|
| ***Primary Care/Case Management*** | • Implement 100 percent pre-admission certification and concurrent review, critical pathways, and other case management tools network-wide<br>• Adopt the Institute of Medicine definition of primary care<br>• Focus on strengthening primary care delivery system by adopting a uniform definition across network & implementing a cost effective staffing plan<br>• Expand availability of alternatives to acute care hospitalization, including 23 hour observation units and hoptel beds<br>• Evaluate and refine primary care model in chronic disease management being piloted at Iowa City<br>• Implement and expand a cost-effective case management program, with a 10 percent improvement by the end of '99 over '98 performance in CSS standard of "Coordination of Care"<br>• Increase portion of patients with an identified primary care provider or team that coordinates services<br>• Renovate primary care space at Des Moines<br>• Renovate ambulatory care space at Knoxville and the Greater Nebraska HCS (Grand Island Division) |
| ***Special Emphasis Programs and Six Disabling Conditions*** | • Evaluate methods for expanding residential care and or community case management programs for the seriously mentally ill<br>• Establish a telemedicine connection between the Vet Centers in Moline and Cedar Rapids with the Iowa City VAMC<br>• SCI/SCD patient satisfaction indicated that about 1/3 (35 percent) patients served noted their satisfaction to be very good or excellent. The goal is to increase this to 80 percent |
| ***Community Based Outpatient Clinics (CBOCs)*** | • Activated CBOC at Norfolk, NE in 11/97<br>• Waterloo, IA in 1/98<br>• Expanded capacity at Mason City, IA<br>• Under consideration/discussion are the following:<br><u>Locations</u><br>Beatrice, NB<br>Dubuque, IA<br>Ft Dodge, IA<br>Marshalltown, IA<br>Ottumwa, IA<br>Sidney, NB<br>Sioux City, IA (Joint venture with Network 13) |
| ***Community Based Care Initiatives*** | • Design and implement an adult day health care program at a State Veterans Home site<br>• Develop a plan for increased utilization of community programs in homemaker/home health aid services, visiting nurse, etc.<br>• Evaluate homeless grants and per diem payment programs for supported housing in community residential care and halfway house facilities |

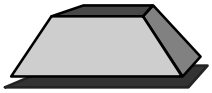
| | |
|---|---|
| ***Improving Clinical and Administrative Information Systems*** | • Install mental health teleconsultation capability between Moline and Cedar Rapids, IA to the Iowa City VAMC, install teleradiology and telepathology services between Des Moines and Knoxville<br>• Implement DSS all sites<br>• Increase use of automated medical record<br>• Pilot test optical imaging of patient records at Omaha VAMC |
| ***Communication*** | • Develop an integrated strategic marketing, communications, and public relations plan<br>• Communicate VA services and benefits to referral sources<br>• Raise awareness of VA successes<br>• Expand development of Internet Web-based informational materials<br>• Develop liaison position to interface with homeless vets and women's groups<br>• Collate data and issue information from veteran and VSO forums<br>• Expand partnership opportunities with community agencies |
| ***Education*** | • Establish the Central Plains Network University with Colleges of Organizational Development, Clinical and Vocational Development, and Communication and Information Technology<br>• Appoint a Network Academic Affiliations Officer<br>• Implement the Residency Realignment Review Committee recommendations<br>• Establish a "Think Tank" for Network 14 to look at trends in healthcare, workplace, education, etc. and make recommendations to the Network Director<br>• Develop formal primary care education programs for network clinicians and administrative staff that emphasize health promotion and prevention, and ensure that 75 percent of all primary care providers attend quarterly education sessions by the end of FY 99 |
| ***Research*** | • Implement the network research strategic plan<br>• Link research and education efforts to network goals, VHA goals, and most importantly, veteran patient care needs<br>• FY98 research initiatives will include providing input to provider profiling measures; enhancing network and other stakeholders' recognition of the value of research to the network and exploring alternative streams of revenue<br>• Continue to meet the recommendations of interdisciplinary Research Advisory Board |
| ***Sharing Agreements*** | • State Veteran Home sharing initiatives are being developed including one in the area of adult day care |

| | |
|---|---|
| ***Contracting Services*** | • Establish a contract with St. Francis Hospital of Grand Island, NE to provide acute care services. Viability study of the inpatient service at VAMC Lincoln is planned with community contracting options under consideration |
| ***Managing Human Resources*** | • Conduct a pilot test staffing mix of physicians, residents, students, physician assistants, and nurse practitioners to evaluate new model for primary care |
| ***Facility and/or Service Consolidations*** | • The Grand Island-Lincoln integration into the VA Greater Nebraska Health Care System has been ongoing<br>• The Des Moines-Knoxville integration into the VA Central Iowa Health Care System is also ongoing<br>• Consolidate non-stat lab tests in Iowa and Nebraska.<br>• Facilities that have not been involved in integrations are also evaluating any internal opportunities to gain efficiencies and improve services.<br>• Network Administrative Service Center: Future planned administrative services include aspects of Human Resources Management, payroll, billing and other "business office" functions |
| ***Emergency Preparedness*** | • Emergency management activity for FY98 will continue to place emphasis on planning, training and exercising. The network and individual medical center (health care system) emergency management plans will be reviewed and updated as necessary. Medical centers will maintain compliance with JCAHO emergency preparedness standards |


## NETWORK STRATEGIC PLAN SUMMARY



**Mission Goal:** The Network Will Be a Fully Integrated Healthcare Delivery System

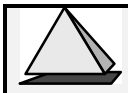
|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Rationalize Acute Inpatient Care and Critical Care Across the Network to Reduce Total Direct Costs and Maintain or Increase Services to Patients** | **'98:** Reduce costs for acute inpatient and critical care by 15 percent from 1997 through bed reduction and aggressive utilization management<br>**'99:** Reduce costs for acute inpatient and critical care by 25 percent from 1997<br>**'00:** Reduce costs for acute inpatient and critical care by 30 percent from 1997 |
| **Consolidate Non-STAT Laboratory Tests for Iowa Facilities and Nebraska Facilities** | **'98:** Reduce costs for laboratory operations by 10 percent from 1997 by integrating non-STAT testing at fewer VA sites or through contracting/sharing arrangements<br>**'99:** Reduce costs for laboratory operations by 20 percent from 1997 |

**Mission Goal :** The Integrated Healthcare Delivery System Will Consistently Provide High Quality Care

| Operating Strategies | Performance Goals |
|---|---|
| **Optimize Efficiency of Primary Care Through the Implementation of a Strategic Staffing Plan** | **'98:** Conduct network-wide staffing analysis to identify potential areas for cost savings in delivering primary care, and complete 50 percent implementation of the resulting plan by the end of FY98<br>**'99:** Implement 100 percent of the strategic staffing plan by the end of FY99<br>**'00:** Monitor effective implementation of plan at each facility |
| **Develop Standardized Reporting Mechanisms, Consistent With National Requirements, Enabling the Network to Evaluate the Effectiveness of Primary Care and Identify Areas for Improvement** | **'98:** All primary care sites will have user-friendly reporting packages to evaluate cost effectiveness, service quality, and clinical quality<br>**'99:** Implement actions to improve effectiveness in at least 3 identified areas for primary care<br>**'00:** Implement actions to improve effectiveness in at least 3 additional identified areas for primary care |

**Mission Goal:** All Eligible Veterans Will Have Reasonable Access to the Appropriate Level of Care

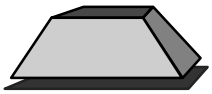
| Operating Strategies | Performance Goals |
|---|---|
| **Improve Access to Primary Care to Optimize Patient Satisfaction and Increase the Market Penetration for Category A Patients** | **'98**: Clinic hours at all facilities will accommodate patient needs. Establish at least one new outpatient clinic |
| **Expand Specialty Consultations and Clinics at Primary Care Sites** | **'98:** Three specialty clinics/consultations will be done by regularly scheduled clinics held within four primary care sites<br>**'99:** Three additional specialty clinics/consultations will be done by regularly scheduled clinics held within four primary care sites<br>**'00:** Three additional specialty clinics/consultations will be done by regularly scheduled clinics held within four primary care sites |



**Mission Goal:** Network Will Be Organized and Staffed to Effectively and Efficiently Accomplish its Goals

**Operating Strategies**

**Reorganize the Network Structure to Reflect a Focus on Strategic Planning and Incorporation of Service Line Planning Concepts**



**Performance Goals**

| | |
|---|---|
| **'98:** | An approved structure for councils, committees, boards, etc., will be published |
| **'98:** | Roles, functions and domains will be developed |
| **'98:** | Council members will be selected and trained |
| **'98:** | Membership of the Strategic Planning Group will be defined by Network policy memorandum |
| **'98:** | The Clinical Advisory Boards will add clinical strategic planning to their functions |

## 1997 SELECTED ACCOMPLISHMENTS

- Clinical Advisory Boards in Primary and Preventive Care, Subspecialty Care, Mental Health, Extended Care, Diagnostic Services, and Special Emphasis Programs--Boards have established clinical guidelines and recommended standardized clinical benefits packages
- Implemented one performance measurement system network-wide
- The VISN University College of Clinical and Vocational Development evaluated managed care and developed a curriculum to meet training requirements
- "Rightsizing" depth and breadth of existing services in order to match service capacity to population needs
- Established network NRM/Equipment Board to prioritize equipment and projects based on health care value in the 5 domains of access, technical quality, patient satisfaction, functional status and cost effectiveness
- Established contract with St. Francis Hospital of Grand Island, NE., to provide acute inpatient care
- Negotiated contracts for mammography, radiation therapy, and orthotics services throughout the network
- Nebraska and Iowa sites established TriCare contracts and provided services to 56 participants
- LOS decreased in all bed services except RMS
- Planning a joint venture with Network 13 for CBOC
- Integrated Des Moines and Knoxville to create VA Central Iowa Health Care System
- Integrated Lincoln and Grand Island to create VA Greater Nebraska Health Care System
- Consolidated purchase and contracting functions in Administrative Service Center
- Developed network video-teleconferencing
- Pilot tested electronic record sharing with Social Security Administration
- Shared access to patient information databases with affiliate institutions
- Network phased in telephone triage, 23-hour observation units, "hoptel" beds and subacute care
- Initiated ambulatory care practice guidelines
- Used InterQual criteria; 100 percent pre-admission certification and concurrent review; critical pathways & case management
- Wrote and distributed a "Guide to Communication Planning" identifying primary and secondary stakeholder groups and potential communications modalities
- Treated 131 percent more veterans with SCI/SCD from '96 to '97
- Increased from biweekly to weekly SCI/SCD clinic at Iowa City
- Decreased acute BDOC/1000, increased outpatient visits secondary to provision of appropriate follow-up and preventative care; increased percentage of surgical procedures on an outpatient basis
- Met network-wide performance standard to provide 98 percent of prosthetics without delay
- Supplemented congressional Rural Communications Network funding to improve information sharing between federal, state, and local agencies in telemedicine, teleradiology, telepathology, and distance learning/video conferencing

***Information as of December 12, 1997. The financial and workload information presented in this package is currently under review for use in budget justifications submitted to Congress.***

**BUDGETARY DATA SET (VISN 14)** **Table B-1**

| | 1997 Base | 1998 Tactical | 1999 Strategic | 2000 Strategic | 2001 Target | 2002 Target | 2003 |
|---|---|---|---|---|---|---|---|
| **1. Financial ($'s in thousands):** | | | | | | | |
| a. Medical Care, Sources of Funding: | | | | | | | |
| VERA Allocation for Medical Care | $287,870 | $278,687 | $277,724 | $277,724 | $277,724 | $277,724 | |
| MCCR Collection [See Note] | $0 | $13,500 | $15,795 | $18,954 | $22,176 | $25,946 | |
| Medicare Reimbursement | $0 | $0 | $1,500 | $2,000 | $2,500 | $3,000 | |
| Tricare Collection | $130 | $150 | $173 | $199 | $229 | $263 | |
| Other Sharing/Reimbursements | $1,396 | $1,536 | $1,689 | $1,858 | $2,044 | $2,248 | |
| Planned Unobligated Balances | ($1,250) | ($4,750) | $1,000 | $1,000 | $1,000 | $2,000 | |
| **Total = Allocation + Revenues** | $288,146 | $289,123 | $297,881 | $301,735 | $305,673 | $311,181 | $0 |
| b. Percent Revenues to Allocation + Revenues | 0.53% | 5.25% | 6.43% | 7.63% | 8.82% | 10.11% | |
| c. Distribution of Funding by selected activities: | | | | | | | |
| Acute Hospital Care | $97,207 | $85,542 | $75,277 | $66,244 | | | |
| Outpatient Care | $101,541 | $106,618 | $111,949 | $117,546 | | | |
| Long-Term Care | $49,689 | $49,689 | $49,689 | $49,689 | | | |
| Total | $248,437 | $241,849 | $236,915 | $233,479 | | | |
| **2. Federal Employment:** | | | | | | | |
| Average Employment (FTE), Total | 3,740 | 3,640 | 3,540 | 3,440 | | | |
| **3. Unique Patient Users (PRPs): [Unduplicated at the National Level]** | | | | | | | |
| a. Total Unique Patient Users (PRPs) | 64,425 | 66,809 | 69,281 | 72,793 | 75,486 | 78,354 | |
| Percent Increase/Decrease from 1997 Base | | 3.70% | 7.54% | 12.99% | 17.17% | 21.62% | -100.00% |
| b. Distribution of PRPs by Eligibility Category: | | | | | | | |
| Category A | 55,664 | 56,978 | 58,607 | 61,195 | | | |
| Category C | 1,739 | 1,756 | 1,791 | 1,827 | | | |
| Non-Veteran Users | 7,022 | 8,075 | 8,883 | 9,771 | | | |
| Total | 64,425 | 66,809 | 69,281 | 72,793 | | | |
| c. Distribution of PRPs by VERA Patient Groups: | | | | | | | |
| Special Care Unique Patient Users | 2,382 | 2,470 | 2,562 | 2,691 | | | |
| Basic Care Unique Patient Users | 62,043 | 64,339 | 66,719 | 70,102 | | | |
| Total | 64,425 | 66,809 | 69,281 | 72,793 | | | |
| **4. Workload Episodes:** | | | | | | | |
| a. Outpatient Visits (Staff & Fee) | 565,297 | 633,133 | 683,784 | 738,487 | | | |
| b. Acute Hospital Care: | | | | | | | |
| Acute Hospital Beds | 496 | 442 | 415 | 373 | | | |
| Acute Hospital ADC | 368 | 376 | 353 | 317 | | | |
| Acute Inpatients Treated | 11,808 | 11,500 | 11,150 | 10,125 | | | |
| c. Long-Term Care: | | | | | | | |
| Long-Term Beds | 399 | 391 | 375 | 360 | | | |
| Long-Term ADC | 351 | 367 | 389 | 427 | | | |
| Long-Term Inpatients Treated | 3,092 | 3,336 | 3,536 | 3,882 | | | |
| **5. Number of Facilities:** | | | | | | | |
| VA Hospitals | 6 | 6 | 6 | 6 | | | |
| VA Nursing Home Care Units | 2 | 2 | 2 | 2 | | | |
| VA Domiciliaries | 2 | 2 | 2 | 2 | | | |
| Outpatient Clinics: | | | | | | | |
| Hospital Based, Independent & Mobile | 6 | 6 | 6 | 6 | | | |
| CBOCs, CBCs, Satellite & Outreach | 6 | 12 | 15 | 18 | | | |
| **6. Financial Measures (Medical Care):** | | | | | | | |
| a. Obligations Per Unique User Analysis (30% network goal): | | | | | | | |
| Obligations Per Unique User | $4,473 | $4,328 | $4,300 | $4,145 | $4,049 | $3,971 | |
| Percent Change from 1997 Base | | -3.24% | -3.87% | -7.33% | -9.48% | -11.22% | |
| Assumed Portion Current Services | | 3.75% | 7.63% | 11.63% | 15.45% | 19.92% | 24.28% |
| Percent Change Net of Current Services | | -6.99% | -11.50% | -18.96% | -24.93% | -31.14% | |
| b. % Change in Unique Patient Users from 1997 base, from line 2a. above (20% network goal) | | 3.70% | 7.54% | 12.99% | 17.17% | 21.62% | -100.00% |
| c. % Revenues to Allocation + Revenues, from line 1b. above (10% network goal) | 0.53% | 5.25% | 6.43% | 7.63% | 8.82% | 10.11% | |
| d. % of Acute Hosp.$s to Tot.of Acute $s + OP $s | 48.91% | 44.52% | 40.21% | 36.04% | | | |
| e. Outpatient Visits Per Unique User | 8.77 | 9.48 | 9.87 | 10.15 | | | |
| f. Med. Care Capital Obligations Per Unique User | $216 | $257 | $340 | $324 | | | |

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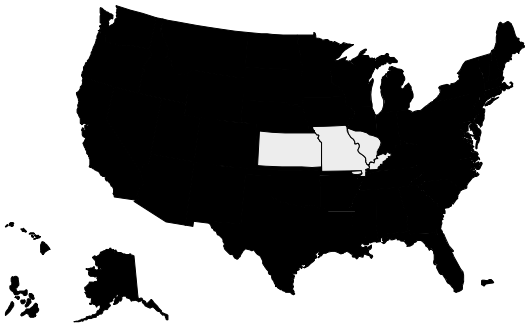
# VA HEARTLAND NETWORK (NETWORK 15)
PLAN SUMMARY

## VISN OVERVIEW



Network 15 is located in the middle of the United States, a mixed density population area with few urban/suburban communities. It covers most of Kansas and Missouri, the southern third of Illinois, and bordering counties in Indiana and Kentucky. The estimated veteran population for the area is 991,200.

## PLAN HIGHLIGHTS

| | |
|---|---|
| ***Quality*** | • Closely monitor efficiency and quality to initiate timely intervention<br>• Provide employees with skills and knowledge necessary to monitor their own performance<br>• Use focus groups to survey patients and provide feedback to VAHN |
| ***Performance Measurement System*** | • Continue implementation of a private sector benchmarking system that provides comparisons to similar facilities (e.g., national teaching) or departments on a quarterly basis; the report includes severity/LOS, productivity/labor utilization, costs/charges, utilization/intensity of service, and financial performance, such as profitability ratios, liquidity ratios, and leverage and solvency ratios<br>• Utilize a performance oversight group with representation from each medical center to closely monitor quality improvement criteria, including customer satisfaction<br>• Continue monthly report card of network specific utilization data re ADC, patients treated, outpatient visits<br>• Utilize National Customer Feedback Center to measure and monitor changes in Customer Service Standards results |
| ***Customer Service*** | • Activate ambulatory care addition at Columbia<br>• Activate outpatient addition at Marion<br>• Expand sharing of clinical resources to reduce patient travel and provide care to remote areas |
| ***Primary Care/Case Management*** | • Implement a system that provides profiling statistics on primary care physicians |

| | |
|---|---|
| ***Special Emphasis Programs and Six Disabling Conditions*** | • Development of budgeting by population to ensure special emphasis programs are funded<br>• Long Term Care/High Cost Task Force identified four long term care programs as eligible for additional funding: domiciliary (St. Louis and Leavenworth), long term care psychiatric patients (chronic only) at Topeka, PTSD patients at Topeka, and SCI patients at St. Louis<br>• Every facility will provide or arrange to provide ambulatory PTSD services |
| ***Community Based Outpatient Clinics (CBOCs)*** | • Carnie, IL - approved/not operational<br><br><u>In Process</u><br>Kirksville, MO<br>Wyandotte County, KS<br>Garden City, KS<br>Hays, KS<br><br><u>Proposed</u><br>Sedalia, MO<br>St. Charles, MO<br>Dodge City, KS<br>McPherson/Platt, KS<br>Pittsburg, KS<br>Belleville, IL<br>Jefferson County, MO<br>Rolla/Ft. Leonard Wood, MO<br>Grand View, MO<br>Nevada, MO<br>Owensboro, KY<br>Missouri State Veterans Homes in Mexico, St. James, St. Louis |
| ***Service Lines*** | • Ambulatory Care Support<br>• Behavioral Medicine<br>• Clinical Support<br>• Specialty Services<br>• Ancillary Services |
| ***Improving Clinical and Administrative Information Systems*** | • Integrate the Decision Support System at Topeka-Leavenworth<br>• Complete installation of standard hardware and software for the local area network and wide area network<br>• Implement the national CIRN and CPRS products to share patient data across sites electronically and to capture data on a standardized format |
| ***Communication*** | • Continue to survey veterans, employees, service organizations, state and local officials, and affiliates to develop accurate assessments of the customer base and its healthcare needs |
| ***Education*** | • Expand educational programs on performance monitoring, customer satisfaction, leadership, computer skills, alternate dispute resolution, and clinical issues |
| ***Research*** | • Require all research programs to develop business plans that demonstrate a direct support of the mission of VHA and a direct relationship to the healthcare needs of veterans |
| ***Sharing Agreements*** | • Evaluate opportunity for sharing space and clinical resources with a community provider at the Marion site |
| ***Contracting Services*** | • Expand the Missouri Veterans State Home contract and offer similar services to the Kansas Veterans State Homes |

| | |
|---|---|
| ***Managing Human Resources*** | • Provide employees with feedback<br>• Distribute key information/minutes to all employees<br>• Increase access to educational programs<br>• Availability of Web site<br>• Mission and vision clearly communicated to employees in order to provide quality of care and health maintenance<br>• Periodic training of all employees to understand performance measurement and quality measures |
| ***Facility and/or Service Consolidations*** | • Integrate patient food production with Veteran Canteen Service food production at Popular Bluff and Wichita<br>• Create a business office to consolidate the functions of payroll, staffing, contracting, and small purchasing<br>• Continue integrating the Topeka and Leavenworth clinical sites |


## NETWORK STRATEGIC PLAN SUMMARY

**Mission Goal:** Build Upon the Baseline of Fiscal Year 1997 With a Clinical Focus

| Operating Strategies | Performance Goals |
|---|---|
| **Increase the number of Category A Veterans Enrolled in the Network** | • Increase access by adding CBOCs in under-served areas<br>• Provide clinical specialists to rural sites on a regularly scheduled basis<br>• Increase sharing of clinical resources through telemedicine |
| **Improve Quality, Functional Status, and Customer Satisfaction and Be an Organization Characterized by Exceptional Accountability** | • Expand implementation of clinical guidelines<br>• Continue implementing managed care<br>• Use primary care providers as healthcare coordinators |

**Mission Goal:** Continue to Move Toward the Goal of 15% Overhead on Administration

| Operating Strategies | Performance Goals |
|---|---|
| **Establish a Network Business Office. Finalize Network Level and Clinical Site Level Organization** | • Integrate two business functions at central locations (payroll and staffing, contracting and small purchasing) |
| **Continue Integrating the Topeka and Leavenworth Clinical Sites** | • Continue combining managerial staff<br>• Provide job placement assistance and employee counseling for the affected staff<br>• Implement new organizational structure at Columbia and Marion congruent with new structure at Topeka, Kansas City, Wichita, Poplar Bluff, and St. Louis<br>• Reduce duplicate functionality at each clinical site as appropriate |

**Mission Goal:** Develop opportunities for income from non-appropriated funding

| Operating Strategies | Performance Goals |
|---|---|
| **Increase Medical Care Cost Fund Collections** | • Allocate MCCF collections to the medical centers according to the Budget by Population formula<br>• Provide healthcare services to active DOD personnel<br>• Expand the Missouri Veterans State Home Contract and offer similar services to the Kansas Veterans State Homes<br>• Provide telemedicine and other related health services to the Bureau of Prisons |

## 1997 SELECTED ACCOMPLISHMENTS

- Developed and implemented a “Budget by Population” formula which ensures that special emphasis programs are funded, that mechanisms for transfer pricing are in place, and that rewards are linked to performance
- Installed and refined technology that allows for network-wide scheduling, sharing of patient data, expanded telemedicine, and video training capabilities
- Installed technology to support a network level nurse call system
- Developed and implemented over 20 clinical guidelines for high frequency disorders specific to the network
- Developed and implemented policy and guidelines for primary care that standardized requirements for level of care and services, quality, staffing and management, roles and responsibilities, panel sizes, data, program evaluation criteria, and education and training
- Implemented tele-dermatology and tele-psychiatry
- Developed and implemented a standardized organizational structure based upon multi-disciplinary units in five of the clinic sites (VAMCs)
- Completed private sector cost benchmarking project and network began expansion to all sites
- Marion site integrated patient food production with Veterans Canteen Service food service
- Established Performance Oversight Group (POG) with representatives from each clinical site to monitor quality improvement criteria
- VAHN selected a Director of Primary Care and a Director of Behavioral Medicine
- Chartered CBOC task force, chaired by Network COO, responsible for analysis of "best" sites and evaluation of CBOC proposals
- Developed several methods to monitor performance: monthly report card, monthly reviews of national performance measures, private sector benchmarking and periodic training for all employees to understand performance measurement
- Developed a Year 2000 Implementation Plan and appointed a Year 2000 Coordinator

***Information as of December 12, 1997. The financial and workload information presented in this package is currently under review for use in budget justifications submitted to Congress.***

**BUDGETARY DATA SET (VISN 15)** **Table B-1**

| | 1997 Base | 1998 Tactical | 1999 Strategic | 2000 Strategic | 2001 Target | 2002 Target | 2003 |
|---|---|---|---|---|---|---|---|
| **1. Financial ($'s in thousands):** | | | | | | | |
| a. Medical Care, Sources of Funding: | | | | | | | |
| VERA Allocation for Medical Care | $615,621 | $612,888 | $612,888 | $612,888 | $612,888 | $612,888 | $612,888 |
| MCCR Collection [See Note] | $0 | $20,176 | $27,072 | $29,443 | $31,414 | $33,464 | $35,500 |
| Medicare Reimbursement | | | | | $1,000 | $3,000 | $4,000 |
| Tricare Collection | | $100 | $800 | $1,000 | $2,500 | $4,600 | $4,800 |
| Other Sharing/Reimbursements | $1,000 | $3,000 | $8,500 | $12,000 | $15,000 | $27,000 | $27,000 |
| Planned Unobligated Balances | ($2,816) | ($866) | ($4,030) | | | | |
| **Total = Allocation + Revenues** | $613,805 | $635,298 | $645,230 | $655,331 | $662,802 | $680,952 | $684,188 |
| b. Percent Revenues to Allocation + Revenues | 0.16% | 3.66% | 5.64% | 6.48% | 7.53% | 10.00% | 10.42% |
| c. Distribution of Funding by selected activities: | | | | | | | |
| Acute Hospital Care | $200,000 | $202,000 | $205,000 | $206,000 | | | |
| Outpatient Care | $210,000 | $215,000 | $220,000 | $225,000 | | | |
| Long-Term Care | $85,000 | $87,000 | $89,000 | $91,000 | | | |
| Total | $495,000 | $504,000 | $514,000 | $522,000 | | | |
| **2. Federal Employment:** | | | | | | | |
| Average Employment (FTE), Total | 7,258 | 7,150 | 7,000 | 7,000 | | | |
| **3. Unique Patient Users (PRPs): [Unduplicated at the National Level]** | | | | | | | |
| a. Total Unique Patient Users (PRPs) | 143,860 | 142,629 | 151,550 | 156,550 | 165,000 | 177,000 | 177,000 |
| Percent Increase/Decrease from 1997 Base | | -0.86% | 5.35% | 8.82% | 14.69% | 23.04% | 23.04% |
| b. Distribution of PRPs by Eligibility Category: | | | | | | | |
| Category A | 126,597 | 125,514 | 133,364 | 137,764 | | | |
| Category C | 5,754 | 5,705 | 6,062 | 6,262 | | | |
| Non-Veteran Users | 11,509 | 11,410 | 12,124 | 12,524 | | | |
| Total | 143,860 | 142,629 | 151,550 | 156,550 | | | |
| c. Distribution of PRPs by VERA Patient Groups: | | | | | | | |
| Special Care Unique Patient Users | 6,550 | 6,550 | 6,550 | 6,550 | | | |
| Basic Care Unique Patient Users | 137,310 | 136,079 | 145,000 | 150,000 | | | |
| Total | 143,860 | 142,629 | 151,550 | 156,550 | | | |
| **4. Workload Episodes:** | | | | | | | |
| a. Outpatient Visits (Staff & Fee) | 1,162,246 | 1,250,000 | 1,450,000 | 1,600,000 | | | |
| b. Acute Hospital Care: | | | | | | | |
| Acute Hospital Beds | 743 | 725 | 725 | 700 | | | |
| Acute Hospital ADC | 380 | 370 | 370 | 370 | | | |
| Acute Inpatients Treated | 19,871 | 19,850 | 19,850 | 19,850 | | | |
| c. Long-Term Care: | | | | | | | |
| Long-Term Beds | 814 | 850 | 900 | 900 | | | |
| Long-Term ADC | 759 | 775 | 800 | 825 | | | |
| Long-Term Inpatients Treated | 12,052 | 12,100 | 12,300 | 12,500 | | | |
| **5. Number of Facilities:** | | | | | | | |
| VA Hospitals | 9 | 9 | 9 | 9 | | | |
| VA Nursing Home Care Units | 6 | 6 | 6 | 6 | | | |
| VA Domiciliaries | 2 | 2 | 2 | 2 | | | |
| Outpatient Clinics: | | | | | | | |
| Hospital Based, Independent & Mobile | 10 | 10 | 10 | 10 | | | |
| CBOCs, CBCs, Satellite & Outreach | 8 | 18 | 24 | 30 | | | |
| **6. Financial Measures (Medical Care):** | | | | | | | |
| a. Obligations Per Unique User Analysis (30% network goal): | | | | | | | |
| Obligations Per Unique User | $4,267 | $4,454 | $4,258 | $4,186 | $4,017 | $3,847 | $3,865 |
| Percent Change from 1997 Base | | 4.38% | -0.21% | -1.90% | -5.86% | -9.84% | -9.42% |
| Assumed Portion Current Services | | 3.75% | 7.63% | 11.63% | 15.45% | 19.92% | 24.28% |
| Percent Change Net of Current Services | | 0.63% | -7.84% | -13.53% | -21.31% | -29.76% | -33.70% |
| b. % Change in Unique Patient Users from 1997 base, from line 2a. above (20% network goal) | | -0.86% | 5.35% | 8.82% | 14.69% | 23.04% | 23.04% |
| c. % Revenues to Allocation + Revenues, from line 1b. above (10% network goal) | 0.16% | 3.66% | 5.64% | 6.48% | 7.53% | 10.00% | 10.42% |
| d. % of Acute Hosp.$s to Tot.of Acute $s + OP $s | 48.78% | 48.44% | 48.24% | 47.80% | | | |
| e. Outpatient Visits Per Unique User | 8.08 | 8.76 | 9.57 | 10.22 | | | |
| f. Med. Care Capital Obligations Per Unique User | $296 | $240 | $204 | $196 | | | |

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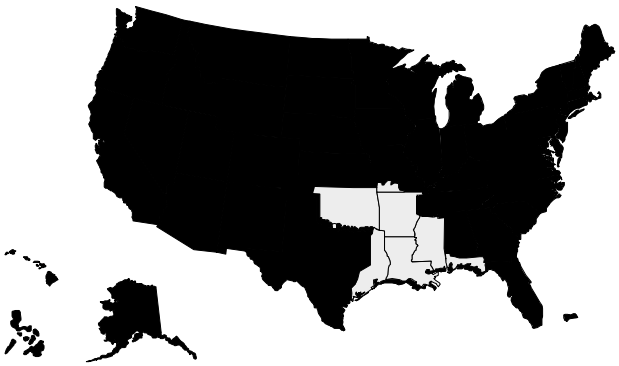
# VETERANS INTEGRATED SERVICE NETWORK (NETWORK 16)
PLAN SUMMARY

## VISN OVERVIEW



VISN 16 provides health care to veterans in Oklahoma, Arkansas, Louisiana, Mississippi and parts of Texas, Missouri, Alabama, and Florida. It is the largest VISN as measured by veteran population, recurring budget and unique veterans served. It spans over 170,000 square miles, ranging from the gulf coast of Florida, through Mississippi, Arkansas and Louisiana, to east Texas and Oklahoma. The demographic, economic and cultural characteristics of this VISN are as diverse as the geography. Mississippi and Arkansas are ranked among the nation's lowest in per capita income. The gulf coast features a large retired military population; Houston, New Orleans and Oklahoma City are densely populated urban areas; and the remainder of the VISN 16 residents live in predominantly rural areas. The estimated FY97 veteran population totaled 1,767,900.

## PLAN HIGHLIGHTS

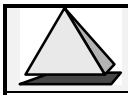
| | |
|---|---|
| ***Quality*** | • Develop and publish criteria for determining best practices and identify best practices within the Network in FY98<br>• Treat 90 percent of all patients using Clinical Guidelines by FY03<br>• Standardize quality management practices within the Network in FY98<br>• Develop system/process to improve patient health education FY98/03<br>• Establish standards for tertiary care in FY98<br>• Evaluate quality of surgery programs and consider consolidations FY98<br>• Implement functional status tool (GAF) with all general mental health, CMI and PTSD programs in FY98/00<br>• Use CQI teams throughout the VISN to share ideas, develop and implement new programs, identify efficiencies and potential revenue opportunities, and improve quality FY98/03<br>• Monitor clinical guidelines developed for 12 disease cohorts for impact on patient outcomes in FY98<br>• Establish case management and clinical protocols/pathways for cancer patients in FY98 |

| | |
|---|---|
| ***Performance Measurement System*** | • Demonstrate quality and consistent clinical practice by assuring that 90 percent of patients have a diagnosis managed by Network guidelines and that performance is measured by defined outcomes in FY99<br>• Establish Customer Service and Marketing Committee to monitor customer service survey performance measures and encourage innovative strategies for improvement FY98/03 |
| ***Customer Service*** | • Ensure that customer service standards and corresponding Network and facility performances are widely shared with customers, stakeholders and employees FY98/00<br>• Implement a continuous feedback system by public relations and marketing committees for identifying, meeting and exceeding customer expectations FY98<br>• Decrease waiting times to 7 days for appointments in primary and specialty care clinics by FY03<br>• Renovate inpatient units to correct patient privacy deficiencies FY98 |
| ***Primary Care/Case Management*** | • Develop a patient case management process across the continuum of care<br>• Expand use of case management for patients with multi-system disease for longitudinal services FY98/00<br>• Relocate Life Support Unit and Urgent Care Clinics to more accessible location next to ambulatory care clinics at Oklahoma City<br>• Provide additional space to accommodate Primary and Ambulatory Care<br>• Modify existing inpatient space to accommodate Ambulatory Care workload at Muskogee and Shreveport FY98 |
| ***Special Emphasis Programs and Six Disabling Conditions*** | • Develop an inventory of SEP services and identify the existing and potential demand for these services, starting with Blind Rehabilitation, Prosthetics and SCI in FY98<br>• Establish primary care teams in all facilities to manage Ex-POW care FY98<br>• Evaluate the impact of eligibility reform on demand for audiology service including hearing aids<br>• Establish TBI case managers to increase percentage of patients able to live independently FY98/00<br>• Increase mammography and Pap smear exam rates to 90 percent by FY03<br>• Conduct a make/buy analysis for provision of Blind Rehab Services within Network FY98/00<br>• Improve short-term survival rates of AIDs patients over previous three years and exceed risk-adjusted community benchmark by FY03<br>• Enhance strength of SCI services to improve customer satisfaction to 90 percent by FY03<br>• Consolidate CMI programs and reduce BDOC and avg. cost per day |

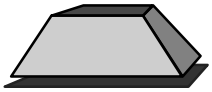
| | |
|---|---|
| ***Community Based Outpatient Clinics (CBOCs)*** | • Panama City, FL; Ft. Walton, FL; Fairhope, AL; Meridian, MS; Mt Home, AR; El Dorado, AR; McAlester, OK; Longview, TX; Harris CT, TX; Bryan College Station, TX; Ponca City, OK; Ada, OK ('98)<br>• Lafayette, LA; Harrison, AR; Waldron, AR; Greenville, MS; Mena, AR; Hot Springs, AR; Poteau, OK; Galveston, TX; Norman, OK; Morgan City, LA; Houma, LA; Covington, LA ('99)<br>• Lake Charles, LA; Branson, MO; Jay, OK; Hattiesburg, MS; Jenks, OK ('00) |
| ***Community Based Care Initiatives*** | • Move appropriate nursing home patients into VA-subsidized residential settings FY98/02<br>• Pilot use of Interqual admission criteria in home care<br>• Redefine mission of NHCU to be transitional care (60/90 max stay) and move toward community placement FY98/02<br>• Evaluate feasibility for full spectrum of comprehensive home care capabilities through HBPC and various contracted sources; evaluate need for Home IV and TPN in plan FY98/00 |
| ***Service Lines*** | • Five Clinical Service Delivery Line Committees: Primary Care, Tertiary Care, Mental Health, Extended Care and Special Emphasis Care<br>• MH Service Line Manager<br>• Administrative Service Delivery Committees include Business Council, Resource Mgmt. Board, Informatics Mgmt. Council, Construction Advisory, Staff Education, DSS Council and Strategic Planning<br>• Service line facility reorganizations at Alexandria, Biloxi and New Orleans<br>• Implement MH service line in Little Rock in FY98 |
| ***Improving Clinical and Administrative Information Systems*** | • Develop coordinated plan to accomplish information infrastructure improvements FY 98/99<br>• Pilot CPRS, physician assistant software, voice recognition transcription, etc. FY98/00<br>• Pilot telemedicine (pathology, nuclear medicine, radiology, psychiatry, dermatology and dentistry) services by FY03 |
| ***Communication*** | • Promote partnership in the workplace through Union representation on VISN committees<br>• Hold Annual Information Summit with stakeholders to highlight accomplishments and upcoming initiatives<br>• Update one-page brochure for PR on strategic plan for FY98 |
| ***Education*** | • Assess education and training needs of all staff<br>• Identify VISN-wide training goals<br>• Identify technologies appropriate for delivery of educational activities |
| ***Research*** | • Identify administrative and clinical improvements at facility level by using HSR&D functional analysis<br>• Establish a Network level research committee |

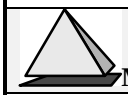
| | |
|---|---|
| ***Sharing Agreements*** | • Explore loaning/leasing space to State Veterans Homes<br>• Assess opportunities to establish joint initiatives with Columbia HCA<br>• Develop survey in FY98 to look at potential sources of revenue and initiatives regarding Enhanced Health Care Resources Sharing Authority<br>• Pursue partnering with DOD, U.S. Bureau of Prisons and USPHS<br>• Implement VISN-wide TriCare contracts<br>• Implement CHAMPVA VISN wide<br>• Expand sharing agreement for Lab and Audiology<br>• Continue/enhance agreements for shared space, high cost services or highly specialized services with affiliates, e.g., sleep labs, electron microscopy, atomic absorption testing |
| ***Contracting Services*** | • Develop approaches to purchase/sell services such as mailroom, golf course management, prepared/convenience foods, dental and laundry services<br>• Consolidate contracting efforts and consolidate transcription services and home oxygen<br>• Coordinate blanket purchase agreements to obtain better pricing as completed with consolidated contracting in FY98<br>• Explore generating revenue from excess laundry capacity |
| ***Managing Human Resources*** | • Provide training opportunities for clinical staff in primary care and case management<br>• Develop career paths with performance expectations and educational activities tied to them |
| ***Facility and/or Service Consolidations*** | • Implement service consolidations in areas such as clinical support activities and consolidated laboratory services<br>• Consider possible consolidation of Radiation Safety/Health Physics in Network or contract at Network level<br>• Analyze nutrition services for possible consolidation and revenue generation |
| ***Emergency Preparedness*** | • Conduct VA/DOD Contingency Exercise<br>• Revise VA/DOD plans<br>• Plan Network emergency response exercise and develop scenarios to test Network's and facilities' response to emergency events |


## NETWORK STRATEGIC PLAN SUMMARY

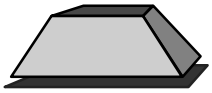


**Mission Goal:** : Provide Excellence in Health Care Value

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Demonstrate Increased Accessibility to Health Care Services by Increasing the Number of Unique Patients Enrolled by 20%** | **'98:** 3 percent change in unique patient users from FY97<br>**'99:** 7.12 percent change from FY97<br>**'00:** 11.40 percent change from FY97 |
| **Establish Equitable Access to Continuum of Care for Enrolled Veterans** | **'98:** Increase the ratio of outpatient visits to inpatient admissions to 38:1<br>**'03:** Increase the ratio to 50:1 |



**Mission Goal:** Provide Excellence in Service as Defined by Our Customers

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Improve Customer Satisfaction** | **'98:** Continue to establish story boards on problems and resolutions from patient surveys in each medical center<br>**'99:** Test measurement of satisfaction in nursing home and intermediate care programs utilizing VAF-10-1465F at one facility<br>**'00:** Implement targeted recommendations from Price Waterhouse study of VHA communication |
| **National Performance Measures Will Be Implemented and Achieved Throughout VISN 16 Network of Care** | **'98-00:** Develop action plan to decrease waiting times in clinics and ancillary services so patients are seen by provider within 30 minutes of scheduled appointment<br>**'03:** Target 20 minutes by FY03. |

| | |
|---|---|
| **Mission Goal:** Be an Organization Characterized by Exceptional Accountability | |
| **Operating Strategies** | **Performance Goals** |
| **Become a Preferred Provider for Veterans Health Care** | **'98:** Explore use of State Veterans Homes for possible use as outpatient clinics, health screening areas, contract clinics and show 20 percent increase in veterans by FY03 |
| **Reduce cost per patient by 30%** | **'98:** 5.36% change from FY97 base<br>**'99:** 4.57% change from FY97 base<br>**'00:** 1.54% change from FY97 base |
| **Mission Goal:** Be an Employer of Choice | |
| **Operating Strategies** | **Performance Goals** |
| **Align Management Practices with Organization Values and Business Strategies** | **'98-00:** Develop flexible staffing practices (e.g., pools of employees with broader skills; use of temporary or contract employees) |
| **Provide Workforce and Organization with the Opportunity to Grow for the Future** | **'98:** 20 hours of education per employee focusing on customer service, CQI and information technology<br>**'00**: Develop network-wide education center, incorporating use of videoconferencing<br>**'03**: 40 hours of education per employee |
| **Mission Goal:** Provide Excellence in Education and Research | |
| **Operating Strategies** | **Performance Goals** |
| **Enhance Research Mission and its Role in Veterans Health Care by Assuring That 100% of Research Projects are Demonstrably Related to VA Missions** | **'98:** Establish Network research committee for oversight of research goals and implementation of tactical actions and reach FY98 performance measure target for funding increase<br>**'99-00:** Provide research access to appropriate DHCP, NT and Internet data for clinical data analysis proposed to assist in establishment of clinical research protocols |
| **Enhance Academic Medical Education Mission** | **'98:** Develop and implement residency assessment tool<br>**'98-00:** Monitor strategic goals established in school of medicine agreements signed in FY97 |

## 1997 SELECTED ACCOMPLISHMENTS

- Exceeded research performance measure
- Developed and received approval for Houston HSR&D implementation of a business plan to become self-sufficient by FY00
- Implemented residency allocation plan
- Expanded access to care by mobile screening programs, MH outreach efforts to homeless, Residential Group Homes, etc.
- Developed a CBOC placement model to determine key locations within Network to expand access points
- Assigned a champion to monitor each performance measure, identify best practices and disseminate information to facilities and ELC; best practices are identified and implemented network-wide
- Initiated VISN-wide Clinical Practice Guidelines for 12 targeted disease cohorts presented in video conference session and used by other VISNs and private facilities
- Piloted and implemented network-wide patient satisfaction monitoring system
- Implemented customer feedback and involvement mechanisms for improved communication via the Internet, "The Voice" (newsletter) and brochure "Journey to the Future"
- Implemented blanket purchase agreements that resulted in savings of $963,836
- Streamlined beneficiary travel by making better use of community resources; resulted in $2 M savings at Houston VAMC (best practice shared with other VAMCs)
- Increased occupancy rate to 85 percent (acute care) and 95 percent (long-term care)
- Decreased BDOC 24 percent
- Decreased beds by 1121
- Included customer service standards in all employees' performance standards
- Use of investigators to identify OWCP abusers resulted in major improvements in program and put individuals into light duty positions; program cost reduction from FY94-97 was 36 percent at Houston VAMC
- Created new career tracks in service line management positions and multi-skilled staffing positions
- Implemented Administrative Officers' voluntary sharing and skills development program at Houston:
- Innovative dispute resolution training on mediation, interest-based bargaining and alternative dispute resolution underway
- Implemented five Clinical Service Delivery Line Committees (Primary Care, Tertiary Care, Mental Health, Extended Care and Special Emphasis Care)
- Developed clinical inventory of inpatient services and identified high cost areas for further review
- Invested $30 million in Information Technology to improve clinical and administrative data driven decision making
- Provided customer service training to most VISN employees
- Established Customer Service Boards at many facilities
- Added home antibiotic and infusion services to some VISN home programs
- Expanded temporary lodging services throughout the VISN
- Instituted parking improvements at three facilities and shuttle services available at four facilities
- Improved elevator and wheelchair access at Alexandria
- Implemented directional signage improvements at Houston and Alexandria
- Developed software program to monitor waiting times to give feedback to all facilities
- Increased primary care resident slots and decreased specialty care residents
- Implemented FIM, ASI, preventive and chronic disease screenings

***Information as of December 12, 1997. The financial and workload information presented in this package is currently under review for use in budget justifications submitted to Congress.***

**BUDGETARY DATA SET (VISN 16)** **Table B-1**

| | 1997 Base | 1998 Tactical | 1999 Strategic | 2000 Strategic | 2001 Target | 2002 Target | 2003 Target |
|---|---|---|---|---|---|---|---|
| **1. Financial ($'s in thousands):** | | | | | | | |
| a. Medical Care, Sources of Funding: | | | | | | | |
| VERA Allocation for Medical Care | $1,135,462 | $1,175,832 | $1,207,332 | $1,212,883 | $1,212,883 | $1,212,883 | $1,212,883 |
| MCCR Collection [See Note] | | $55,613 | $62,740 | $69,522 | $75,700 | $82,013 | $88,574 |
| Medicare Reimbursement | | | | | $19,134 | $31,015 | $45,727 |
| Tricare Collection | $13 | $392 | $719 | $990 | $1,234 | $1,575 | $1,929 |
| Other Sharing/Reimbursements | $3,568 | $4,351 | $5,109 | $5,207 | $5,940 | $9,298 | $10,455 |
| Planned Unobligated Balances | | | | | | | |
| **Total = Allocation + Revenues** | $1,139,043 | $1,236,188 | $1,275,900 | $1,288,602 | $1,314,891 | $1,336,784 | $1,359,568 |
| b. Percent Revenues to Allocation + Revenues | 0.31% | 4.88% | 5.37% | 5.88% | 7.76% | 9.27% | 10.79% |
| c. Distribution of Funding by selected activities: | | | | | | | |
| Acute Hospital Care | $442,702 | $418,649 | $414,235 | $400,319 | | | |
| Outpatient Care | $362,293 | $455,001 | $487,481 | $510,374 | | | |
| Long-Term Care | $101,753 | $101,753 | $100,714 | $99,675 | | | |
| Total | $906,748 | $975,403 | $1,002,430 | $1,010,368 | | | |
| **2. Federal Employment:** | | | | | | | |
| Average Employment (FTE), Total | 14,105 | 14,304 | 14,163 | 14,023 | | | |
| **3. Unique Patient Users (PRPs): [Unduplicated at the National Level]** | | | | | | | |
| a. Total Unique Patient Users (PRPs) | 258,716 | 266,477 | 277,136 | 288,221 | 299,750 | 311,740 | 314,857 |
| Percent Increase/Decrease from 1997 Base | | 3.00% | 7.12% | 11.40% | 15.86% | 20.50% | 21.70% |
| b. Distribution of PRPs by Eligibility Category: | | | | | | | |
| Category A | 225,718 | 232,488 | 241,788 | 251,459 | | | |
| Category C | 11,427 | 11,769 | 12,240 | 12,730 | | | |
| Non-Veteran Users | 21,571 | 22,220 | 23,108 | 24,032 | | | |
| Total | 258,716 | 266,477 | 277,136 | 288,221 | | | |
| c. Distribution of PRPs by VERA Patient Groups: | | | | | | | |
| Special Care Unique Patient Users | 9,236 | 9,513 | 9,894 | 10,289 | | | |
| Basic Care Unique Patient Users | 249,480 | 256,964 | 267,242 | 277,932 | | | |
| Total | 258,716 | 266,477 | 277,136 | 288,221 | | | |
| **4. Workload Episodes:** | | | | | | | |
| a. Outpatient Visits (Staff & Fee) | 2,271,242 | 2,339,135 | 2,426,603 | 2,517,322 | | | |
| b. Acute Hospital Care: | | | | | | | |
| Acute Hospital Beds | 1,640 | 1,517 | 1,475 | 1,455 | | | |
| Acute Hospital ADC | 1,394 | 1,289 | 1,254 | 1,237 | | | |
| Acute Inpatients Treated | 49,372 | 49,125 | 48,879 | 48,635 | | | |
| c. Long-Term Care: | | | | | | | |
| Long-Term Beds | 1,212 | 1,212 | 1,212 | 1,212 | | | |
| Long-Term ADC | 1,151 | 1,151 | 1,151 | 1,151 | | | |
| Long-Term Inpatients Treated | 8,423 | 8,423 | 8,423 | 8,423 | | | |
| **5. Number of Facilities:** | | | | | | | |
| VA Hospitals | 12 | 12 | 12 | 12 | | | |
| VA Nursing Home Care Units | 8 | 8 | 8 | 8 | | | |
| VA Domiciliaries | 2 | 2 | 2 | 2 | | | |
| Outpatient Clinics: | | | | | | | |
| Hospital Based, Independent & Mobile | 12 | 12 | 12 | 12 | | | |
| CBOCs, CBCs, Satellite & Outreach | 18 | 30 | 42 | 47 | | | |
| **6. Financial Measures (Medical Care):** | | | | | | | |
| a. Obligations Per Unique User Analysis (30% network goal): | | | | | | | |
| Obligations Per Unique User | $4,403 | $4,639 | $4,604 | $4,471 | $4,387 | $4,288 | $4,318 |
| Percent Change from 1997 Base | | 5.36% | 4.57% | 1.54% | -0.36% | -2.61% | -1.93% |
| Assumed Portion Current Services | | 3.75% | 7.63% | 11.63% | 15.45% | 19.92% | 24.28% |
| Percent Change Net of Current Services | | 1.61% | -3.06% | -10.09% | -15.81% | -22.53% | -26.21% |
| b. % Change in Unique Patient Users from 1997 base, from line 2a. above (20% network goal) | | 3.00% | 7.12% | 11.40% | 15.86% | 20.50% | 21.70% |
| c. % Revenues to Allocation + Revenues, from line 1b. above (10% network goal) | 0.31% | 4.88% | 5.37% | 5.88% | 7.76% | 9.27% | 10.79% |
| d. % of Acute Hosp.$s to Tot.of Acute $s + OP $s | 54.99% | 47.92% | 45.94% | 43.96% | | | |
| e. Outpatient Visits Per Unique User | 8.78 | 8.78 | 8.76 | 8.73 | | | |
| f. Med. Care Capital Obligations Per Unique User | $183 | $256 | $303 | $256 | | | |

# VA HEART OF TEXAS HEALTHCARE NETWORK (NETWORK 17)
PLAN SUMMARY

## VISN OVERVIEW

The network covers 134 counties, 132 in Texas and two in Oklahoma. The I-35 corridor, which is the principal transportation route between the U.S. and Mexico, encompasses 70 percent of the network's total veteran population in 31 counties. Veterans aged 45 to 54 represent the largest segment of the network's total veteran population. The estimated FY97 veteran population was 964,100. As the first VA network to integrate all of its facilities into health care systems, VISN 17 has enjoyed an advantage in increasing access, providing high quality patient care, and optimizing utilization of capital assets and personnel.

## PLAN HIGHLIGHTS

| | |
|---|---|
| ***Quality*** | • Increase proportion of HCFA ambulatory care procedures performed on an ambulatory basis<br>• Activate the ambulatory surgery expansion project at the South Texas System<br>• Activate automated, pre-analytical processing of urine specimens at the North Texas System<br>• Activate robotic pharmaceutical filling system at the South Texas System<br>• Activate a preventive medicine telecare program at the North Texas System<br>• Activate lithotripsy program at the North Texas System<br>• Activate a bed tower project at the Central Texas System<br>• Replace physiological monitoring system at the South Texas System<br>• Activate Phases I, II, and III of PACS at the South Texas System |
| ***Performance Measurement System*** | • Match total network operating beds to total network workload requirements<br>• Increase fiscal year percentage of performed HCFA ambulatory surgery procedures<br>• Increase fiscal year Category A veteran users<br>• Meet fiscal year target of 98 percent for completed C&P requests reported by VBA as sufficient<br>• Increase network Chronic Disease Index performance<br>• Raise network Prevention Index performance<br>• Implement 12 nationally developed network-wide clinical practice |

| | |
|---|---|
| | guidelines, two of which are for Special Emphasis populations<br>• Chronic Disease Index and Preventive Index systems have reminder system with incentive plan<br>• Chaplains and social workers have increased end-of-life planning counseling with incentive plan<br>• Employee focus groups will be conducted in FY 1998 to specifically define areas of weakness with follow-up group reunions convened to measure improvement |
| ***Customer Service*** | • Create ten 23-hour stay beds to support expanded ambulatory surgery at the North Texas System<br>• Expand mobile screening clinics at the Central Texas System<br>• Activate health promotion and disease prevention fairs at the South Texas System<br>• Conduct focus group moderator training to increase number of moderators<br>• Conduct primary care focus groups and reunions to identify improvements in customer service<br>• The Primary Care Focus Group project will continue with additional groups and reunions convened to assess and measure service improvement in order to better understand and pursue weaknesses identified in the National Customer Feedback Center (NCFC) surveys<br>• Conduct family member focus groups to develop an understanding of the needs and concerns of dependents<br>• Expand respite and hospice programs by four beds at the North Texas System<br>• Activate post-hospital care team at the South Texas System |
| ***Primary Care/Case Management*** | • Establish outreach primary care teams to conduct twice-a-week medical health screenings at seven Vet Centers<br>• Expand ambulatory surgery at the Central Texas System<br>• Review published practice guidelines for case management<br>• Activate case management teams at the South Texas System<br>• Select and implement case management guidelines with particular attention to multi-system disease and special emphasis programs<br>• Review monthly feedback reports from EPRP, intervening clinically as necessary<br>• Increase ambulatory surgery use of observation beds and hoptel beds<br>• Simplify primary care enrollment process<br>• Assign 100 percent of current users to an individual health care professional or to a team of professionals |
| ***Special Emphasis Programs and Six Disabling Conditions*** | • Expand Outpatient Spinal Cord Injury program at the Central Texas System<br>• Establish, in conjunction with the South Central Regional Readjustment Counseling Service, video-conferencing link between Laredo Vet Center and VAMC San Antonio |
| ***Community Based Outpatient Clinics (CBOCs)*** | • Bonham Primary Care Network, McKinney, Decatur, Brownwood, Bryan-College Station (joint with VISN 16), Seguin, New Braunfels, San Marcos, San Antonio, Beeville, Kingsville, Alice, Uvalde ('98)<br>• Eastland, Denton, Georgetown, Copperas Cove ('99)<br>• Cleburne, Greenville, Corsicana, Stephenville ('00) |

| | |
|---|---|
| ***Community Based Care Initiatives*** | • Activate a hospital based home care program serving the Temple/Austin area<br>• Expand home-based primary care to include 24-hour infusion therapy at the North Texas System<br>• Activate community residential care program at the Central Texas system |
| ***Service Lines*** | • While service lines have been implemented at the system level, there are no plans to implement network-wide service lines in the absence of supportive research; coordination of Special Emphasis Programs across systems is similar to this approach |
| ***Improving Clinical and Administrative Information Systems*** | • Establish automated processes to capture and monitor provider profiles<br>• Expand DSS to perform service line analysis, clinical performance measure modeling, and clinical quality management at Central Texas System<br>• Complete implementation of computerized patient record system at the Central Texas System |
| ***Communication*** | • Expand membership of network marketing and communications committee to increase effectiveness in stakeholder education and communication<br>• Network speakers bureau<br>• Town hall meetings<br>• Internet Web page |
| ***Education*** | • Procure network-wide education and training tracking system<br>• Become a "virtual university" with the North, Central, and South Texas Systems providing educational programs that serve as network models<br>• Initiate prosthetics residency program at the North Texas System<br>• Activate satellite learning center computer lab at the South Texas System<br>• Develop all employee newsletter summarizing patient focus group findings and clinical guidelines for practitioners<br>• Establish Network instructor academy to enhance teaching techniques |
| ***Research*** | • Expand participation in Facilitators of Applied Clinical Trials to increase pool of scientific projects for Network investigators<br>• Activate Regional Comprehensive Epilepsy Center at the South Texas System<br>• Activate Geriatrics Center of Excellence at the Central Texas System |
| ***Sharing Agreements*** | • Add second MRI unit through joint ownership program with the University Health System at the South Texas System<br>• Replace linear accelerator at Scott and White Memorial Hospital through joint ownership program at the Central Texas System |
| ***Contracting Services*** | • Activate CHAMPVA Program at the Central and South Texas Systems<br>• Activate TriCare medical/surgical and pharmacy agreements at the Central Texas System<br>• Activate TriCare pharmacy agreement at the South Texas System<br>• Activate TriCare Selected Reserve Dental Programs<br>• Activate network-wide healthcare services agreement with State of Texas National Guard and Reserve |

| | |
|---|---|
| ***Managing Human Resources*** | • Establish network-wide career transition program<br>• Review feasibility of network-wide upward mobility program |
| ***Facility and/or Service Consolidations*** | • First network to integrate all of its facilities (seven medical centers and 15 clinics) into three health care systems (i.e., North, Central, and South) |
| ***Emergency Preparedness*** | • Assign two Area Emergency Managers to provide support to the Network to coordinate emergency preparedness exercises |

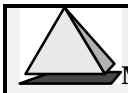

## NETWORK STRATEGIC PLAN SUMMARY

**Mission Goal:** Decrease the System-wide Average Cost (Expenditure) per Patient by 30 Percent

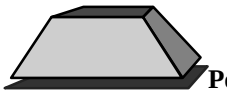
| Operating Strategies | Performance Goals |
|---|---|
| **Shift from Inpatient to Outpatient Care** | **'98:** Decrease 27,923 BDOC through operating bed reductions<br>**'99:** Perform 80 percent of HCFA procedures on an ambulatory basis<br>**'00:** Close 90 total operating beds throughout network |
| **Promote Effective Resource Management** | **'98:** Establish automated processes to capture and monitor provider profile<br>**'99:** Undertake administrative reviews in food service and fee services programs<br>**'00:** Conduct administrative reviews in energy management and ADP hardware maintenance and repair programs |

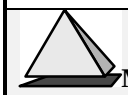
**Mission Goal:** Increase the Number of Users of the Veterans Health Care System by 20 Percent

| Operating Strategies | Performance Goals |
|---|---|
| **Improve Access to Care** | **'98:** Provide 250 contract ambulatory surgery procedures to Lower Rio Grande Valley patients<br>**'99:** Activate hospital based home care program serving Temple/Austin area<br>**'00:** Activate CBOCs at Cleburne, Greenville, Corsicana, and Stephenville |
| **Implement Managed Care** | **'98:** Activate case management team<br>**'99:** Select and implement case management guidelines for network, devoting special attention to multi-system disease and special emphasis programs<br>**'00:** Continue to expand additional practice guidelines for case management |

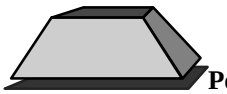


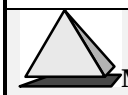
**Mission Goal:** Increase Percentage of the Operating Budget Obtained From Non-appropriated Sources to 10 Percent

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Diversify the Network's Funding Base** | **'98:** Activate CHAMPVA Program at the Central and South Texas Systems<br>**'99:** Expand regional and national agreements with the Federal Bureau of Prisons for pathology and laboratory medicine, laundry, and related services<br>**'00:** Add 257 new Category C users and increase MCCR collections by $1.8M |



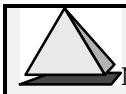
**Mission Goal:** Exceed by 10 Percent the Proportion of Patients of Other Large Health Care Providers Who Achieve Maximal Functional Potential

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Assess Health Outcomes of Substance Abuse Patients** | **'98:** Expand implementation of ASI throughout network and establish monitoring mechanisms to insure ongoing application of this assessment tool |

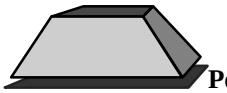


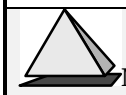
**Mission Goal:** Increase to 99 Percent the Proportion of Research Projects Demonstrably Related to the Health Care of Veterans or to Other Missions of the DVA

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Develop Network Research Program That is Responsive to VA Needs and Promotes Investigative Opportunities** | **'98:** Activate network New Investigators Award Program<br>**'99:** Activate Gastrointestinal Research Center at the Central Texas System<br>**'00:** Expand the psychosis research program |

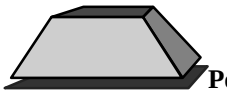


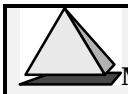
**Mission Goal:** Meet Goal of 95 Percent of Physician House Staff and Other Trainees Rating VA Educational Experience as Equal or Superior to Their Other Academic Training

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Realign Medical Residency Positions to Insure They Meet Present and Future Health Care Needs of Both the Network and the Nation** | **'98:** Add three FTE "super tech" multi-skilled technicians to assist medical residents<br>**'99:** Continue to reduce specialty resident positions with reinvestment into additional primary care positions to meet three-year assigned goal<br>**'00:** Same as FY99 |

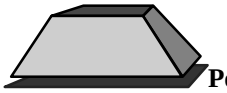


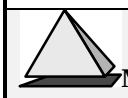
**Mission Goal:** Increase to 2 Percent, or 40 Hours/Year, the Amount of an Employee's Paid Time Spent in Continuing Education to Promote and Support Quality Improvement or Customer Service

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Develop Employee Education and Training Programs Necessary to Provide Quality Service to Patients** | **'98:** Provide 20 hours of education to each network employee<br>**'99:** Provide 25 hours of continuing education to each network employee<br>**'00:** Provide 30 hours of continuing education to each network employee |
| **Provide a Quality Workplace That is Safe, Secure, and Promotes a High Level of Job Satisfaction** | **'98:** Conduct network analysis of OWCP costs and develop cost stabilization/reduction goals<br>**'99:** Conduct reunion of Phase I employee focus groups to identify improvements in workplace and job satisfaction<br>**'00:** Conduct reunion of Phase II employee focus groups to identify improvements in workplace and job satisfaction |



**Mission Goal:** Increase to 100 Percent the Number of Employees Able to Appropriately Describe How Their Work Helps Meet the Mission of the "New VA"

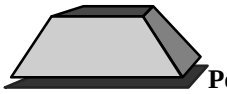
|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Empower Employees** | **'98:** Develop an information packet or fact sheet for all employees<br>**'99:** Assess the effectiveness of the career transition program |
| **Enhance Information Systems** | **'98:** Conduct a medical staff telemedicine needs assessment<br>**'99:** Construct DSS database at the North Texas System<br>**'00:** Procure additional CPRS workstations for the network |



**Mission Goal:** Increase to 100 Percent the Number of Employees who, when Queried, are Able to Appropriately Describe How Their Work Helps Meet the Mission of the "New VA"

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Promote Employee Communications on the "New VA"** | **'99:** Modify information packet or fact sheet based on FY98 employee feedback |
| **Ensure Staff Have Tools Equipment to Provide Quality Services to Patients** | **'00:** Procure commercial administrative and clinical software for the network |

**Mission Goal:** Increase to 90 Percent the Proportion of Patients Who Rate the Quality of VHA Health Care as Equal to or Better Than What They Receive From Others

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Improve Customer Service** | **'98:** Develop approaches for shared decision-making<br>**'99:** Conduct Phase I-III focus groups on clinical guidelines selected for FY99<br>**'00:** Conduct reunion of Phase I-III clinical guidelines focus group patients to identify improvements in customer service |
| **Implement Managed Care** | **'98:** Continue to monitor clinical staff adherence to the 18 guidelines currently in use<br>**'99:** Revise the Network Risk Management Program based on identified opportunities for improvement |

## 1997 SELECTED ACCOMPLISHMENTS

- BDOC reductions occurred across all hospital and long-term care bed sections with largest reductions in acute hospital bed sections of medicine (12 percent), surgery (21 percent), and contract hospital (37 percent)
- Closed 146 operating beds
- Pharmacy Service operations were standardized through a network-wide contract covering the return of outdated and used drugs
- Seven administrative and seven clinical program reviews were conducted by the Nntwork
- Expanded ambulatory surgery and invasive diagnostic procedure capacity by 30 percent
- Implemented 100 percent pre-admission and variable real time review network-wide
- Network established CBOCs at five sites: Brownsville, Del Rio, Eagle Pass, Pleasant Grove, and Tyler
- Network generally achieved waiting time goals in primary care and other clinics, with medical staffs of the three systems providing same-day appointments for urgent/emergent case referrals
- Network initiated a contract with Recovered Assets, Inc. to recover outstanding credits for the North, Central, and South Texas Systems
- TriCare medical/surgical services were expanded to South Texas' Kerrville and San Antonio VAMCs and North Texas' Bonham VAMC
- Implemented ASI network-wide as an assessment tool in the field of substance abuse and treatment
- Expanded application of FIM for lower extremity amputees network-wide through continuing education of nursing personnel
- Finalized plans to participate in the Cleveland Education Center's 4 ½ -day career transition training program
- Network Marketing and Communications Committee distributed an "All Employee Survey"
- Network Education and Employee Relations Subcommittee completed a network inventory of training curriculum and an educational needs assessment linking curriculum with strategic planning priorities
- Network Health Care Services Committee, in coordination with Associate Chiefs of Staff for Ambulatory Care, developed a standardized definition, delivery model, and enrollment process based on pre-existing program structures and current community standards
- Each system conducted an annual self-audit of CBOC operations
- Network expanded application of clinical guidelines from 5 to 18
- Network Information Resources Management Subcommittee developed an integrated IRM plan that promotes a coordinated approach to information systems development
- Activated 30-bed SCI Center at VAMC Dallas
- Activated ambulatory care addition, MRI facility, replacement ICU monitoring system, additional CT scanner, additional ultrasound imaging system, and additional mammography unit at VAMC Temple
- Activated acute psychiatry and blind rehabilitation renovation and addition at VAMC Waco
- Activated ambulatory care renovation at VAMC Marlin
- Activated additional Optifill automated pharmaceutical dispensing unit and canteen food service and dining area renovation at VAMC San Antonio
- Activated 10-bed Hospice Unit renovation at VAMC Kerrville
- Activated $.5 million fire pump and sprinkler system upgrade at Bonham Medical Center
- Activated $.47 million digital subtraction angiography upgrade at Temple Medical Center
- Activated $.37 million replacement radiographic/fluroscopic unit at Marlin Medical Center
- Adopted a standardized definition, delivery model, and enrollment process which contributes technical quality through a consistent/enhanced primary care product for patients and program clarity for employees
- Activated $.6 million replacement nuclear medicine gamma camera at San Antonio Medical Center
- Activated $.15 million Primary Care Clinic involving the consolidation of clinics at Kerrville
- Integrated the Bonham and Dallas Medical Centers into the VA North Texas Health Care System
- Implemented tactical planning initiatives monitoring groups to ensure accomplishment of 1997 initiatives

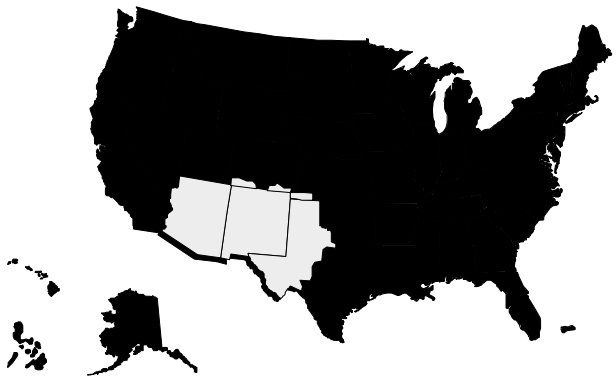
***Information as of December 12, 1997. The financial and workload information presented in this package is currently under review for use in budget justifications submitted to Congress.***

**BUDGETARY DATA SET (VISN 17)** **Table B-1**

| | 1997 Base | 1998 Tactical | 1999 Strategic | 2000 Strategic | 2001 Target | 2002 Target | 2003 Target |
|---|---|---|---|---|---|---|---|
| **1. Financial ($'s in thousands):** | | | | | | | |
| a. Medical Care, Sources of Funding: | | | | | | | |
| VERA Allocation for Medical Care | $623,090 | $647,698 | $648,495 | $648,495 | $648,495 | $648,495 | $648,495 |
| MCCR Collection [See Note] | | $24,663 | $26,862 | $28,670 | $30,484 | $32,392 | $33,287 |
| Medicare Reimbursement | | | | | $11,348 | $19,396 | $19,896 |
| Tricare Collection | $260 | $545 | $1,090 | $2,180 | $4,360 | $8,720 | $8,720 |
| Other Sharing/Reimbursements | $6,203 | $6,630 | $7,272 | $8,197 | $9,547 | $11,564 | $11,648 |
| Planned Unobligated Balances | | | | | | | |
| **Total = Allocation + Revenues** | $629,553 | $679,536 | $683,719 | $687,542 | $704,234 | $720,567 | $722,046 |
| b. Percent Revenues to Allocation + Revenues | 1.03% | 4.69% | 5.15% | 5.68% | 7.91% | 10.00% | 10.19% |
| c. Distribution of Funding by selected activities: | | | | | | | |
| Acute Hospital Care | $289,285 | $285,649 | $282,229 | $278,999 | | | |
| Outpatient Care | $168,620 | $189,073 | $200,134 | $210,370 | | | |
| Long-Term Care | $50,580 | $52,477 | $54,513 | $56,693 | | | |
| Total | $508,485 | $527,199 | $536,876 | $546,062 | | | |
| **2. Federal Employment:** | | | | | | | |
| Average Employment (FTE), Total | 8,427 | 8,640 | 8,740 | 8,729 | | | |
| **3. Unique Patient Users (PRPs): [Unduplicated at the National Level]** | | | | | | | |
| a. Total Unique Patient Users (PRPs) | 141,730 | 145,982 | 150,361 | 154,872 | 168,036 | 179,958 | 182,537 |
| Percent Increase/Decrease from 1997 Base | | 3.00% | 6.09% | 9.27% | 18.56% | 26.97% | 28.79% |
| b. Distribution of PRPs by Eligibility Category: | | | | | | | |
| Category A | 127,794 | 131,628 | 135,578 | 139,645 | | | |
| Category C | 8,089 | 8,332 | 8,582 | 8,839 | | | |
| Non-Veteran Users | 5,847 | 6,022 | 6,201 | 6,388 | | | |
| Total | 141,730 | 145,982 | 150,361 | 154,872 | | | |
| c. Distribution of PRPs by VERA Patient Groups: | | | | | | | |
| Special Care Unique Patient Users | 6,524 | 6,647 | 6,766 | 6,899 | | | |
| Basic Care Unique Patient Users | 135,206 | 139,335 | 143,595 | 147,973 | | | |
| Total | 141,730 | 145,982 | 150,361 | 154,872 | | | |
| **4. Workload Episodes:** | | | | | | | |
| a. Outpatient Visits (Staff & Fee) | 1,168,511 | 1,247,084 | 1,313,589 | 1,383,647 | | | |
| b. Acute Hospital Care: | | | | | | | |
| Acute Hospital Beds | 1,030 | 918 | 858 | 772 | | | |
| Acute Hospital ADC | 684 | 670 | 662 | 656 | | | |
| Acute Inpatients Treated | 29,546 | 29,068 | 28,592 | 28,117 | | | |
| c. Long-Term Care: | | | | | | | |
| Long-Term Beds | 1,351 | 1,373 | 1,343 | 1,339 | | | |
| Long-Term ADC | 1,222 | 1,246 | 1,216 | 1,212 | | | |
| Long-Term Inpatients Treated | 4,290 | 4,738 | 4,738 | 4,738 | | | |
| **5. Number of Facilities:** | | | | | | | |
| VA Hospitals | 7 | 7 | 7 | 7 | | | |
| VA Nursing Home Care Units | 6 | 6 | 6 | 6 | | | |
| VA Domiciliaries | 2 | 2 | 2 | 2 | | | |
| Outpatient Clinics: | | | | | | | |
| Hospital Based, Independent & Mobile | 7 | 7 | 7 | 7 | | | |
| CBOCs, CBCs, Satellite & Outreach | 15 | 29 | 33 | 37 | | | |
| **6. Financial Measures (Medical Care):** | | | | | | | |
| a. Obligations Per Unique User Analysis (30% network goal): | | | | | | | |
| Obligations Per Unique User | $4,442 | $4,655 | $4,547 | $4,439 | $4,191 | $4,004 | $3,956 |
| Percent Change from 1997 Base | | 4.80% | 2.36% | -0.07% | -5.65% | -9.86% | -10.94% |
| Assumed Portion Current Services | | 3.75% | 7.63% | 11.63% | 15.45% | 19.92% | 24.28% |
| Percent Change Net of Current Services | | 1.05% | -5.27% | -11.70% | -21.10% | -29.78% | -35.22% |
| b. % Change in Unique Patient Users from 1997 base, from line 2a. above (20% network goal) | | 3.00% | 6.09% | 9.27% | 18.56% | 26.97% | 28.79% |
| c. % Revenues to Allocation + Revenues, from line 1b. above (10% network goal) | 1.03% | 4.69% | 5.15% | 5.68% | 7.91% | 10.00% | 10.19% |
| d. % of Acute Hosp.$s to Tot.of Acute $s + OP $s | 63.18% | 60.17% | 58.51% | 57.01% | | | |
| e. Outpatient Visits Per Unique User | 8.24 | 8.54 | 8.74 | 8.93 | | | |
| f. Med. Care Capital Obligations Per Unique User | $183 | $226 | $220 | $215 | | | |

# VA SOUTHWEST HEALTHCARE NETWORK (NETWORK 18)
PLAN SUMMARY

## VISN OVERVIEW



In terms of size, VISN 18 is one of the largest networks. If the land mass of the entire Network were superimposed on the East Coast, its boundaries would span from the Atlantic Ocean all the way to the Mississippi River, covering all or portions of thirteen eastern states. It contains approximately 361,000 square miles of urban, rural, and frontier settings, including all of Arizona and New Mexico, the western half of Texas, and small parts of Colorado, Nevada, and Oklahoma. Major population centers, such as Phoenix and Albuquerque, are surrounded by vast areas with very few residents. The VISN 18 veteran population totals approximately 807,700.

## PLAN HIGHLIGHTS

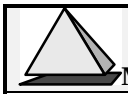
| | |
|---|---|
| ***Quality*** | • Assure continuity of care during patient transfers and referrals using uniform processes throughout the network<br>• Integrate Vet Centers into the network's seamless continuum of care<br>• Assign case manager to all high risk patients<br>• Develop and implement shared decision-making programs to involve patients in healthcare decisions<br>• Provide inpatient services at sites where volume is sufficient to assure efficiency and quality care<br>• Implement and utilize Total Quality Improvement (TQI) processes (e.g., process action teams) for addressing organizational issues and concerns<br>• Target at least one key outpatient process in each facility and use quality techniques to improve that process<br>• Implement the Quality System Survey (QSS) or similar instrument |
| ***Performance Measurement System*** | • Continue application of fifteen clinical guidelines at all network facilities<br>• Continue disease prevention and wellness programs at all facilities<br>• Continue implementing measures that advance quality of care such as the Chronic Disease Index (CDI) and Prevention Index (PI)<br>• Measure percentage of patients receiving follow-up ASI, based on cohort of patients who received initial ASI in FY97<br>• Measure percentage of mental health patients who have follow-up within 30 days |

| | |
|---|---|
| ***Customer Service*** | • Involve facilities in more community services such as health fairs, stand downs, and educational programs<br>• Improve volunteer services and training and establish a youth volunteer program<br>• Develop a uniform guest service package for implementation by all facilities |
| ***Primary Care/Case Management*** | • Assign a case manager as part of each high risk patient's team by September 1999<br>• Realign residency positions towards primary care<br>• Improve utilization review capabilities at all facilities<br>• Include the ambulatory care addition at Tucson in the FY99 budget request for completion in FY 01<br>• Expand outpatient space at Amarillo in FY98<br>• Complete Phase I construction of the ambulatory care addition at Phoenix during FY98, and phase II during FY 2000 |
| ***Special Emphasis Programs and Six Disabling Conditions*** | • Extend training by staff from the Albuquerque inpatient Spinal Cord Injury Rehabilitation unit to teams at other network facilities |
| ***Community Based Outpatient Clinics (CBOCs)*** | • Establish as many as 37 CBOCs throughout the network's sparsely populated, largely rural area in order to provide better access to patient care services<br>• Casa Grande, AZ; Flagstaff, AZ; Hobbs, NM; Kingman, AZ; Kearney, AZ; Marana, AZ; Odessa, TX; Safford, AZ; Show Low, AZ; Stamford, TX; Truth or Consequences, NM; Yuma, AZ; ('98)<br>• Bisbee, AZ; Green Valley/Nogales, AZ; Monahans, TX ('99) |
| ***Community Based Care Initiatives*** | • Insure that VISN facilities participate in community services such as stand downs, health fairs, health screenings and educational programs<br>• Encourage established clinics to develop community program components such as health education screening to meet the unique needs (including specialty needs) of the minority populations |
| ***Service Lines*** | • Continue implementing "service lines" at the local level |
| ***Improving Clinical and Administrative Information Systems*** | • Expand Decision Support Systems (DSS) for operations and management use<br>• Ensure a quality user support system by recruiting staff for critical positions and standardizing software and specified hardware capabilities/configurations at all facilities |
| ***Communication*** | • Enhance communications throughout the organization by developing innovative employee incentive /award programs focusing on the internal customer<br>• Target outreach to Vietnam Era, Persian Gulf, women, and Native American veterans, and to other military members recently separated from the service |
| ***Education*** | • Implement shared training among facilities by utilizing teleconferencing<br>• Expand educational capabilities of network facilities to include revenue-generating activities<br>• Optimize affiliates' educational resources to improve facility benefit<br>• Realign residency positions towards primary care |

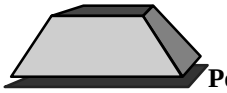
| | |
|---|---|
| ***Research*** | • Increase funding for mission related research |
| ***Sharing Agreements*** | • Strengthen relationships with DOD and other federal healthcare entities by conducting outreach to additional potential sharing partners and by increasing sharing at William Beaumont Army Medical Center<br>• Evaluate potential sharing arrangements between Amarillo and Cannon Air Force Base<br>• Develop an agreement between the Phoenix VAMC and the Phoenix Memorial Hospital for acquisition of an MRI and testing services |
| ***Contracting Services*** | • Task the Consolidated Contracting and Procurement Work Group in FY 98 to develop performance standards measuring the effectiveness of each contracting activity<br>• Perform cost benefit analysis for medical/surgical prime vendors<br>• Provide long-term psychiatry services within the Network by establishing a contract with the Big Spring State Mental Hospital |
| ***Managing Human Resources*** | • Increase the ratio of non-physician practitioners as appropriate by increasing the number of mid-level practitioners used for primary care and by implementing the recommendations of a national task group |
| ***Facility and/or Service Consolidations*** | • Identify and evaluate services and programs for potential consolidation based on cost/benefit analyses including tangible and intangible costs and savings<br>• Evaluate possible facility consolidations; initially, El Paso, Albuquerque and/or William Beaumont Army Medical Center |
| ***Emergency Preparedness*** | • Refine Emergency Management Plan that delineates responsibilities of each participant, operations concepts, a notification system, reporting requirements, and education/training and exercises |

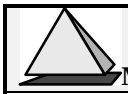

## NETWORK STRATEGIC PLAN SUMMARY

| | |
|---|---|
| **Mission Goal:** Advance Quality Healthcare | |
| **Operating Strategies** | **Performance Goals** |
| **Shift from a Hospital-Based System to Primary Care** | • Assign patients in each facility to a primary care provider<br>• Decrease inpatient utilization and track decline by acute BDOC/1000 SSNs<br>• Increase use of home care |
| **Implement Clinical Practice Guidelines and Appropriate Pathways** | • Implement Nationally selected guidelines |
| **Mission Goal:** Provide a Positive Patient Care Environment | |
| **Operating Strategies** | **Performance Goals** |
| **Invest in Attractive, Functional Facilities and Insure a Safe Environment for Patients and Employees** | • Complete the design program for the Tucson outpatient addition, with the goal of awarding a contract by '99<br>• Assure that the highest priority needs for patient surroundings and clinical improvements receive adequate consideration<br>• Invest in safety, security, emergency preparedness, infrastructure, and utility systems |
| **Enhance End of Life Settings for Terminally Ill Patients** | • Obtain a Robert Wood Johnson grant for innovative end of life care |

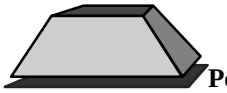


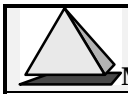
**Mission Goal:** Improve Customer Relations

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Promote Customer-Friendly Processes** | • Each network facility will develop a "customer focused" system to identify opportunities for improvement and a process to implement improvements<br>• Facilities will conduct an internal assessment of customer service programs based on an integrated approach to customer service. From this assessment, facilities will develop a specific plan<br>• Each facility will target at least one key outpatient process and use quality techniques to improve that process |
| **Establish an Ongoing Customer Feedback and Information System** | • Each network facility will support and promote the development of a "customer intelligence system" (selected quantitative and qualitative data) which is designed to communicate the organizational expectations, needs, satisfiers and dissatisfiers of patients on a consistent, regular basis<br>• VISN 18 will develop a standardized comprehensive feedback mechanism and management system, to provide customer information on a regular, consistent basis<br>• The patient feedback methodology and management system will allow comparison between facilities on a quarterly basis to allow for timely/immediate responses for improvement |

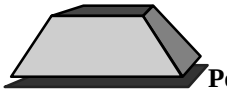


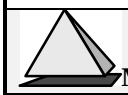
**Mission Goal:** Become an Employer of Choice

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Increase the Amount of Education and Training Provided for Each Employee** | • Increase in each network facility collaboration and shared educational programming, develop an education infrastructure that supports employee learning and achieves the learning goals of the facility, and ensure that education and training programs are accessible to all employees. Ensure that each employee receives 32 hours of education relating to job duties<br>• Develop and provide a common supervisory training program to all network facilities<br>• Increase the proportion of educational opportunities available through technology based mechanisms including computer based CD-ROM, Internet, satellite, etc. |
| **Increase Employees' Sense of Value to the Organization** | • Support employees access to innovative educational activities to assist their understanding of continuing changes in the workplace<br>• Implement Employee Education System programs designed to assist employees in managing transitions as a result of VHA changes<br>• Provide access to "empowerment" opportunities (e.g., self-directed teams) |

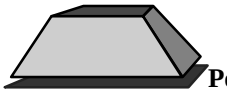


**Mission Goal:** Expand Access To and Integration of Healthcare Services

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Locate CBOCs in VHA Under-served Areas** | • Activate approved CBOC sites<br>• Identify appropriate CBOC sites by obtaining demographic information about veteran needs<br>• Encourage established clinics to develop community program components such as health education and screening to meet the unique needs (including specialty needs) of minority populations |
| **Eliminate Gaps and Overlaps in Health Care Services** | • Develop a list of standardized services to be available at each facility and care site (either VA or contract)<br>• Evaluate remaining services to determine feasibility of centralization/referral versus local/contract |



**Mission Goal:** Enhance User-friendly Communications and Information Systems.

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Implement the Computerized Patient Record System (CPRS)** | • Prepare each Network facility to implement the CPRS in FY98<br>• Install horizontal and vertical cabling<br>• Install necessary networking and peripheral components |
| **Enhance Communication Systems Among All Sites** | • Develop a network-based plan to implement TIP at each network facility<br>• Develop an information and communication migration plan that will address strategies for telemedicine<br>• Perform an assessment of telephone systems to ensure effective communications and upgrade as appropriate<br>• Implement Exchange and Internet access cascading through the organization<br>• Implement video-conferencing |

## 1997 SELECTED ACCOMPLISHMENTS

- BDOC decreased approximately 25 percent from FY96 to FY97
- Rural medicine initiative with University of New Mexico established medical resident training positions at clinics in two remote areas
- Percentage of surgical and diagnostic procedures performed in an ambulatory setting increased by 25 percent from mid FY96 to mid FY97
- Six CBOCs were activated; 15 are in the planning stage
- Women's Health Centers activated in four medical centers
- Major construction expanded Prescott NHCU from 60 to 120 beds
- State-of-the-art ambulatory surgical program implemented at El Paso
- Four TriCare contracts have been negotiated with network facilities
- Microsoft Exchange activated at six of seven network facilities
- Phoenix sponsored an on-site "fair" at which higher learning institutions presented programs, entrance requirements, costs, tuition assistance programs, etc.
- Through partnering arrangements and the VHA Employee Education System, Prescott offered CEU/CME opportunities at a greatly reduced cost
- Developed uniform processes, including coordinator positions, to transfer and/or refer patients within the network and pilot tested electronic transfer form
- Service lines have been implemented locally by facilities in consultation with the network
- Phoenix and Albuquerque increased the number of patients treated and reduced waiting times by expanding the outpatient programs for the seriously mentally ill and PTSD
- Albuquerque recently earned a national TriCare designation as a specialized treatment service for neurological disorders and brain injury
- Integrated Provider Practice Models of primary care delivery enhanced inpatient and outpatient care at all medical centers
- Mental Health providers have integrated large segments of veterans into the primary care delivery model
- El Paso enhanced imaging technology and access to services through procurement of CT unit and PAC system
- Intra-facility work groups from clinical and administrative disciplines at Albuquerque and Big Spring developed assessment processes to expedite triage and treatment of emergent outpatients
- Several medical centers significantly improved their C&P processes and the percentage of sufficient requests for C&P exams has improved to current levels in excess of 99 percent

***Information as of December 12, 1997. The financial and workload information presented in this package is currently under review for use in budget justifications submitted to Congress.***

**BUDGETARY DATA SET (VISN 18)** **Table B-1**

| | 1997 Base | 1998 Tactical | 1999 Strategic | 2000 Strategic | 2001 Target | 2002 Target | 2003 Target |
|---|---|---|---|---|---|---|---|
| **1. Financial ($'s in thousands):** | | | | | | | |
| a. Medical Care, Sources of Funding: | | | | | | | |
| VERA Allocation for Medical Care | $518,392 | $540,241 | $554,642 | $575,195 | $575,195 | $575,195 | $575,195 |
| MCCR Collection [See Note] | | $21,545 | $23,493 | $26,430 | $31,767 | $36,343 | $36,343 |
| Medicare Reimbursement | | | | | $7,555 | $12,829 | $12,829 |
| Tricare Collection | $0 | $55 | $105 | $175 | $225 | $300 | $300 |
| Other Sharing/Reimbursements | $9,604 | $10,603 | $11,033 | $12,403 | $13,378 | $14,418 | $14,418 |
| Planned Unobligated Balances | | | | | | | |
| **Total = Allocation + Revenues** | $527,996 | $572,444 | $589,273 | $614,203 | $628,120 | $639,085 | $639,085 |
| b. Percent Revenues to Allocation + Revenues | 1.82% | 5.63% | 5.88% | 6.35% | 8.43% | 10.00% | 10.00% |
| c. Distribution of Funding by selected activities: | | | | | | | |
| Acute Hospital Care | $171,474 | $174,510 | $169,426 | $165,902 | | | |
| Outpatient Care | $224,448 | $251,331 | $268,934 | $291,003 | | | |
| Long-Term Care | $44,707 | $52,092 | $57,749 | $64,491 | | | |
| Total | $440,629 | $477,933 | $496,109 | $521,396 | | | |
| **2. Federal Employment:** | | | | | | | |
| Average Employment (FTE), Total | 6,170 | 6,560 | 6,704 | 6,917 | | | |
| **3. Unique Patient Users (PRPs): [Unduplicated at the National Level]** | | | | | | | |
| a. Total Unique Patient Users (PRPs) | 146,639 | 158,634 | 165,013 | 171,993 | 179,000 | 186,500 | 186,500 |
| Percent Increase/Decrease from 1997 Base | | 8.18% | 12.53% | 17.29% | 22.07% | 27.18% | 27.18% |
| b. Distribution of PRPs by Eligibility Category: | | | | | | | |
| Category A | 120,904 | 130,794 | 136,052 | 141,808 | | | |
| Category C | 6,305 | 6,821 | 7,097 | 7,396 | | | |
| Non-Veteran Users | 19,430 | 21,019 | 21,864 | 22,789 | | | |
| Total | 146,639 | 158,634 | 165,013 | 171,993 | | | |
| c. Distribution of PRPs by VERA Patient Groups: | | | | | | | |
| Special Care Unique Patient Users | 4,751 | 5,060 | 5,181 | 5,315 | | | |
| Basic Care Unique Patient Users | 141,888 | 153,574 | 159,832 | 166,678 | | | |
| Total | 146,639 | 158,634 | 165,013 | 171,993 | | | |
| **4. Workload Episodes:** | | | | | | | |
| a. Outpatient Visits (Staff & Fee) | 1,302,733 | 1,409,297 | 1,465,966 | 1,527,976 | | | |
| b. Acute Hospital Care: | | | | | | | |
| Acute Hospital Beds | 756 | 711 | 668 | 628 | | | |
| Acute Hospital ADC | 625 | 604 | 568 | 534 | | | |
| Acute Inpatients Treated | 26,739 | 25,135 | 23,627 | 22,209 | | | |
| c. Long-Term Care: | | | | | | | |
| Long-Term Beds | 663 | 669 | 706 | 728 | | | |
| Long-Term ADC | 552 | 636 | 670 | 692 | | | |
| Long-Term Inpatients Treated | 2,945 | 2,972 | 3,135 | 3,232 | | | |
| **5. Number of Facilities:** | | | | | | | |
| VA Hospitals | 6 | 6 | 6 | 6 | | | |
| VA Nursing Home Care Units | 6 | 6 | 6 | 6 | | | |
| VA Domiciliaries | 1 | 1 | 1 | 1 | | | |
| Outpatient Clinics: | | | | | | | |
| Hospital Based, Independent & Mobile | 8 | 8 | 8 | 8 | | | |
| CBOCs, CBCs, Satellite & Outreach | 22 | 34 | 37 | 37 | | | |
| **6. Financial Measures (Medical Care):** | | | | | | | |
| a. Obligations Per Unique User Analysis (30% network goal): | | | | | | | |
| Obligations Per Unique User | $3,601 | $3,609 | $3,571 | $3,571 | $3,509 | $3,427 | $3,427 |
| Percent Change from 1997 Base | | 0.22% | -0.83% | -0.83% | -2.55% | -4.83% | -4.83% |
| Assumed Portion Current Services | | 3.75% | 7.63% | 11.63% | 15.45% | 19.92% | 24.28% |
| Percent Change Net of Current Services | | -3.53% | -8.46% | -12.46% | -18.00% | -24.75% | -29.11% |
| b. % Change in Unique Patient Users from 1997 base, from line 2a. above (20% network goal) | | 8.18% | 12.53% | 17.29% | 22.07% | 27.18% | 27.18% |
| c. % Revenues to Allocation + Revenues, from line 1b. above (10% network goal) | 1.82% | 5.63% | 5.88% | 6.35% | 8.43% | 10.00% | 10.00% |
| d. % of Acute Hosp.$s to Tot.of Acute $s + OP $s | 43.31% | 40.98% | 38.65% | 36.31% | | | |
| e. Outpatient Visits Per Unique User | 8.88 | 8.88 | 8.88 | 8.88 | | | |
| f. Med. Care Capital Obligations Per Unique User | $184 | $167 | $161 | $156 | | | |

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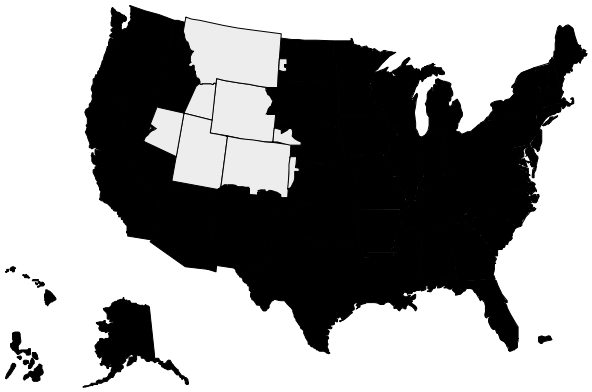
# VA ROCKY MOUNTAIN NETWORK (NETWORK 19)
PLAN SUMMARY

## VISN OVERVIEW



The network provides services at eight facilities in Colorado, Montana, Utah and Wyoming It is one of the largest VA networks in terms of geographic area with highly varied topographical features including the Rocky Mountains. The distribution of VA facilities within the network is not optimal for accessibility. Distances as great as 700 miles exist between the medical centers. The network is marked by great differences in population patterns from the urban areas of Denver and Salt Lake City to some of the least densely populated areas in the country. The estimated FY97 veteran population was 669,800.

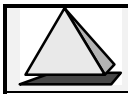
## PLAN HIGHLIGHTS

| | |
|---|---|
| ***Quality*** | • Review and analyze data presented through evaluation of NSQIP report by 3/31/98<br>• Appoint clinically trained patient travel coordinators by 12/31/97 to assure quality of care during transit<br>• Establish provider profile by 3/31/98<br>• Enhance outpatient services and increase penetration to assure mental health patients are availed quality care in the most appropriate venue<br>• Meet or exceed community standards for quality in the areas served<br>• Increase to 2 percent or 40 hours per year the amount of employees paid time that is spent in continuing education that promotes and supports quality improvement and customer service |
| ***Performance Measurement System*** | • Directly link planning with the overall VHA strategic direction and performance measures<br>• Establish performance based evaluations and ratings for all employees<br>• The network will develop specific performance requirements to address attainment of scores equivalent to or higher than the national average as reported in the FY97 customer service standards for inpatient and outpatient activity by June 30, 1998<br>• Medical centers will evaluate the effectiveness of the performance system implemented April 1, 1997, and make appropriate adjustments for the introduction of the April 1, 1998, rating period |

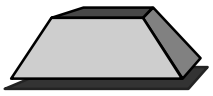
| | |
|---|---|
| ***Customer Service*** | • Identify patient advocacy groups that represent special interests and involve them in network planning<br>• Identify areas in need of improvement for patient satisfaction by using focus groups in selected communities<br>• Initiate network-wide customer service plan |
| ***Primary Care/Case Management*** | • Conduct network-wide training to increase use of case managers for each primary care team<br>• Establish primary care as the means by which all care is integrated, coordinated and authorized in the network<br>• Investigate opportunities for providing primary care in state nursing homes by April 30, 1998<br>• All consultants/specialists will communicate with the primary care provider assigned to patients they are treating<br>• A minimum 90 percent of patients will be assigned to a primary care provider or team by September 30, 1998<br>• Ensure the productivity of all primary care practitioners by adopting panel sizes by June 30, 1998<br>• Implement Primary Care Management Modules at each medical center by December 30, 1997 |
| ***Special Emphasis Programs and Six Disabling Conditions*** | • SMI: Develop an assertive community treatment program in conjunction with expanding community based outpatient clinic in Colorado Springs<br>• Seventy-five percent of mental health inpatients discharged from an inpatient bed will be seen within 30 days by 9/30/98<br>• Improve the penetration of mental health services in the network<br>• Increase accessibility to specialty care at VAMC Denver by shortening PTSD program from 11 to 6 weeks<br>• Evaluate capabilities to support Network with advanced specialized gender-specific services in Denver and Salt Lake City, such as stereotactic breast biopsies, endometrial ablations, cryo procedures, etc.<br>• Identify network clinical coordinator for homeless<br>• Develop for smaller medical centers a telemedicine program for consultative services for amputees<br>• Assign a case manager to every SCD patient identified as having cognitive difficulties or special needs<br>• Pursue development of Blind Rehabilitation Outreach Programs at Denver and Salt Lake City |
| ***Community Based Outpatient Clinics (CBOCs)*** | • '98:Aurora, CO; Greeley, CO; Montrose, CO; Fort Collins, CO; Riverton, WY; Bozeman/Big Timber, MT; Colorado Springs, CO (expand); Provo, UT; Layton, UT; Rock Springs, WY; Denver CO; St. George, UT; Salt Lake City, UT and 2 frontier CBOCs with 2 more in FY'99<br>• Investigate the potential for establishing CBOCs at the following sites: Cortez, CO (Grand Junction); Alamosa, CO (Fort Lyon); Williston, ND (Miles City), Torrington, WY (Cheyenne) and Scottsbluff, NE (Cheyenne) |

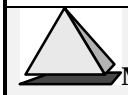
| | |
|---|---|
| ***Community Based Care Initiatives*** | • Establish mental health services as part of community based outpatient clinic operations and community structure<br>• Establish an assertive community treatment modeled program at Cheyenne, Fort Harrison, Grand Junction, Billings/Miles City and Sheridan by September 30, 1998<br>• Healthcare services will be delivered in the most appropriate setting and will utilize community capacity to maximize access to care when it is best for patient care and most cost effective |
| ***Service Lines*** | • Clinical coordinators have been appointed as advisors only (no line authority) in the following areas: Primary Care, Performance Improvement, Surgery, Utilization Management, Mental Health, Tumor Registry, Long Term Care, Nursing, Telemedicine, Dental, Pharmacy, Women's Health, Laboratory, Clinical Research, Pharmacy, Academic Affiliations, C&P Exams, Patient Representative. Select additional clinical coordinators as needed |
| ***Improving Clinical and Administrative Information Systems*** | • Implement Electronic Patient Record System (EPRS) by 12/1/98<br>• Complete establishment of DSS program in all VAMCs by 6/30/99<br>• Complete TIP by 9/30/98<br>• Establish network-wide area network for teleconferencing use by 1/30/98 |
| ***Communication*** | • Refine analysis of marketing opportunities<br>• Expand practitioner's communication course (particularly for facilities scoring poorly on patient satisfaction survey)<br>• Continue network newsletter and stakeholder/network meetings |
| ***Education*** | • Develop network education plan that will coordinate network training and align with strategic targets and operational strategies<br>• Conduct training program for staff providing care for SCI patients (no SCI centers in VISN)<br>• Develop education program to provide training on make/buy decisions |
| ***Research*** | • Develop a network level HSR&D study targeting 2-3 direct patient care issues<br>• Continue the VAMC Denver research project to computerize guidelines related to Ischemic Heart Disease (IHD) |
| ***Sharing Agreements*** | • Task each medical center to inventory current sharing services by December 31, 1997 and identify new opportunities by March 31, 1998 |
| ***Contracting Services*** | • Task the Network Acquisition Service Center to evaluate 3 levels of acquisition to ascertain which level of contracting provides best overall value for VA<br>• Establish contracts to provide care for DOD<br>• Investigate the feasibility of a network-wide air ambulance contract based on criteria of service, quality and reduced cost |
| ***Managing Human Resources*** | • Provide training to key persons to improve understanding of the Medicare process<br>• The network will identify training priorities and funding levels over the five-year time frame |
| ***Emergency Preparedness*** | • Refine emergency preparedness plan<br>• Continue coordinating contingency plans with Federal Emergency Management Agency, Department of Defense, U.S. Public Health Service, and other federal, state and community agencies. |


## NETWORK STRATEGIC PLAN SUMMARY

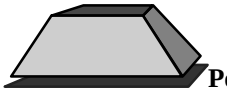


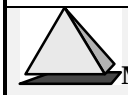
**Mission Goal:** Increase Number of Users of Veterans Healthcare Services by 20%

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Increase the Number of Enrollees in Categories 1-6 in the Network by FY02** | **'98:** Treat additional 3,100 enrollees in Categories 1-6<br>**'99:** Treat additional 3,150 enrollees in Categories 1-6<br>**'00:** Treat additional 3,150 enrollees in Categories 1-6 |
| **Shift Medical Care from Inpatient to Outpatient Focus** | **'98:** Reduce avergage LOS in residential PTSD programs to an average of 6 weeks or fewer<br>**'99:** Reduce avg. LOS for acute inpatient mental health to 12 days or fewer |

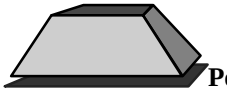


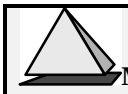
**Mission Goal**: Increase Percentage of Operating Budget Obtained from Non-appropriated Sources to 10% of Total

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Establish a Structure for Defining and Acquiring Non-appropriated Funds** | **'98:** Establish revenue work groups at each VAMC and network<br>**'99:** Task Work Groups to design and implement training program for key staff |

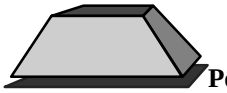


**Mission Goal:** Redistribute Healthcare Services in Network Consistent with Distribution of Veteran Population

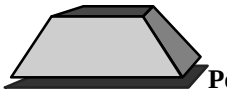
|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Improve Penetration of Mental Health Services in the Network** | **'98:** Increase percentage of SC/NSC veterans using mental health services from FY96 rate of 6.4 percent to national avg. of 7.6 percent<br>**'99:** Increase percentage to 8 percent |



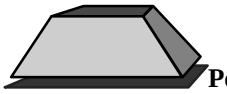
**Mission Goal:** Establish Primary Healthcare as the Means to Integrate, Coordinate and Authorize All Care in the Network

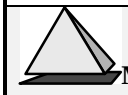
|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Adopt Benchmarks for Establishing Primary Care as Driver of Healthcare Delivery in VISN** | **'98:** Primary care will authorize all patient referrals to specialists/consultants by 9/30/98<br>**'99:** Evaluate effectiveness of compliance |

**Mission Goal**: Provide Care at an Equal or Lower Cost Than Other Providers in the Area

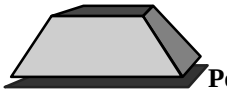
|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Reduce Acquisition Costs and Optimize Fee Basis Expenditures in Network** | **'98:** Reduce funds expenditure of Network Acquisition Center for supplies and services by minimum two times their operating budget<br>**'99:** Reduce Center expenditures by another 10 percent |
| **Reduce Operation Costs in Network through Program Controls and through Application of Information Systems** | **'98:** Assess telemedicine and telepsychiatry applications<br>**'99:** Approved applications will be implemented by 12/31/98 |

**Mission Goal:** Meet or Exceed Community Standards for Quality in the Area It Serves

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Improve Follow-up of Discharged Patients** | **'98:** 75 percent of mental health inpatients discharged from inpatient beds will be seen within 30 days |



**Mission Goal:** Increase to 90% Proportion of Patients Reporting VA Healthcare As Very Good or Excellent and As Equivalent or Better Than That They Receive From Other Providers

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Increase Patient Access to Patient Program Information** | **'98:** Establish Internet web site page on Internet on VA services for patients |

| | |
|---|---|
| **Mission Goal:** Increase Employee Time Spent in Continuing Education to 2% or 40 Hours Per Year | |
| **Operating Strategies** | **Performance Goals** |
| **Develop priority areas for training funds** | **'98:** Develop and present 20 hours of training in: customer service-patient/physician shared decision making; JCAHO training for non-clinicians; and MCCR for clinical and support staff |
| **Mission Goal:** Increase to 100% the Number of Employees Able to Describe How Their Work Helps Meet the Mission of the "New VA" | |
| **Operating Strategies** | **Performance Goals** |
| **Improve Responses from Employee Survey** | **'98:** Assess recently completed employee survey, recommend improvements and implement recommendations<br>**'98:** Educate and inform employees about strategic plan and direction of VHA |
| **Mission Goal:** Establish Performance Based Evaluations and Ratings for All Employees | |
| **Operating Strategies** | **Performance Goals** |
| **Identify Employees Required to Develop Performance-Based Ratings/Evaluations** | **'98:** Evaluate effectiveness of performance system implemented on 4/1/97 and make appropriate adjustments for introduction of 4/1/98 rating period |
| **Mission Goal:** Establish Network Information System That Contributes to Implementation of All Strategic Planning Targets | |
| **Operating Strategies** | **Performance Goals** |
| **Establish an Information Structure and Plan** | **'98:** Establish an Internet network home page<br>**'99:** Complete network telephone switch updates |
| **Develop Prioritized Clinical Information Applications** | **'98:** Establish network CPRS pilot at Sheridan<br>**'99:** Establish EMR network-wide |

## 1997 SELECTED ACCOMPLISHMENTS

- Greater emphasis was placed on outpatient care, including increased ambulatory surgery and reduction of inpatient bed days
- The network reduced approximately 450 hospital beds
- Negotiated contracts for all VAMCs to treat TriCare/CHAMPUS patients (with Merit Behavioral Care Corporation for mental health care)
- Established process to implement, maintain and evaluate CEM program and worked with FEMA, DOD, USPHS and community agencies as appropriate
- Continued Cheyenne surgery services provision of care for CHAMPUS patients
- Orientation program for Assertive Community Treatment completed
- Closed Inpatient Substance Abuse Programs at Cheyenne, Denver, Fort Harrison and Salt Lake City
- Reduced inpatient substance abuse beds at Sheridan
- Denver closed inpatient PTSD unit and established PTSD Residence Unit
- Sheridan reduced inpatient PTSD and acute psychiatric beds
- Fort Lyon reduced long-term and acute psychiatric beds
- Miles City closed all hospital beds and contracted with local hospital for inpatient care
- Dental eligibility guides distributed to network medical centers; Dental Service resource shifts complete
- Physician/Patient Communication Course presented at all medical centers
- VAMC Denver attained CARF accreditation
- HBPC program closed at Denver while retained in Salt Lake City with new criteria; evaluations due by 6/30/98
- Utilization Management Plan adopted at each medical center with expanded criteria of 100 percent pre-admission review and length of stay oversight
- Emergency Preparedness Plan completed

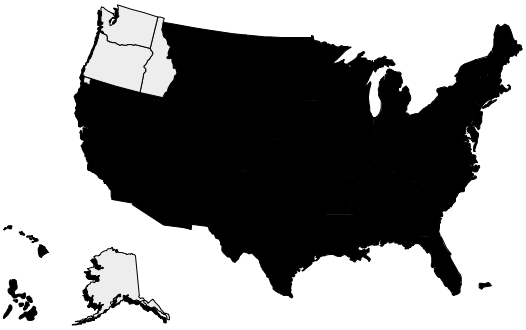
***Information as of December 12, 1997. The financial and workload information presented in this package is currently under review for use in budget justifications submitted to Congress.***

**BUDGETARY DATA SET (VISN 19)** **Table B-1**

| | 1997 Base | 1998 Tactical | 1999 Strategic | 2000 Strategic | 2001 Target | 2002 Target | 2003 Target |
|---|---|---|---|---|---|---|---|
| **1. Financial ($'s in thousands):** | | | | | | | |
| a. Medical Care, Sources of Funding: | | | | | | | |
| VERA Allocation for Medical Care | $384,501 | $395,629 | $395,629 | $395,629 | $395,629 | $395,629 | $395,629 |
| MCCR Collection [See Note] | $0 | $14,000 | $16,244 | $18,457 | $20,731 | $22,974 | $21,333 |
| Medicare Reimbursement | $0 | $0 | $0 | $0 | $8,500 | $12,000 | $12,000 |
| Tricare Collection | $0 | $100 | $1,000 | $3,000 | $5,000 | $7,000 | $7,000 |
| Other Sharing/Reimbursements | $0 | $1,000 | $1,000 | $2,000 | $2,500 | $3,000 | $3,000 |
| Planned Unobligated Balances | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Total = Allocation + Revenues** | $384,501 | $410,729 | $413,873 | $419,086 | $432,360 | $440,603 | $438,962 |
| b. Percent Revenues to Allocation + Revenues | 0.00% | 3.68% | 4.41% | 5.60% | 8.50% | 10.21% | 9.87% |
| c. Distribution of Funding by selected activities: | | | | | | | |
| Acute Hospital Care | $88,386 | $86,618 | $84,886 | $83,188 | | | |
| Outpatient Care | $112,324 | $114,570 | $116,862 | $119,199 | | | |
| Long-Term Care | $37,682 | $37,682 | $37,682 | $37,682 | | | |
| Total | $238,392 | $238,870 | $239,430 | $240,069 | | | |
| **2. Federal Employment:** | | | | | | | |
| Average Employment (FTE), Total | 4,577 | 4,601 | 4,494 | 4,430 | | | |
| **3. Unique Patient Users (PRPs): [Unduplicated at the National Level]** | | | | | | | |
| a. Total Unique Patient Users (PRPs) | 82,825 | 85,945 | 89,065 | 92,185 | 95,305 | 99,061 | 99,061 |
| Percent Increase/Decrease from 1997 Base | | 3.77% | 7.53% | 11.30% | 15.07% | 19.60% | 19.60% |
| b. Distribution of PRPs by Eligibility Category: | | | | | | | |
| Category A | 72,806 | 75,549 | 78,291 | 81,034 | | | |
| Category C | 3,976 | 4,125 | 4,275 | 4,425 | | | |
| Non-Veteran Users | 6,043 | 6,271 | 6,499 | 6,726 | | | |
| Total | 82,825 | 85,945 | 89,065 | 92,185 | | | |
| c. Distribution of PRPs by VERA Patient Groups: | | | | | | | |
| Special Care Unique Patient Users | 2,798 | 2,903 | 3,009 | 3,114 | | | |
| Basic Care Unique Patient Users | 80,027 | 83,042 | 86,056 | 89,071 | | | |
| Total | 82,825 | 85,945 | 89,065 | 92,185 | | | |
| **4. Workload Episodes:** | | | | | | | |
| a. Outpatient Visits (Staff & Fee) | 753,788 | 723,940 | 714,091 | 644,243 | | | |
| b. Acute Hospital Care: | | | | | | | |
| Acute Hospital Beds | 361 | 314 | 314 | 314 | | | |
| Acute Hospital ADC | 265 | 265 | 265 | 265 | | | |
| Acute Inpatients Treated | 14,896 | 14,896 | 14,896 | 14,896 | | | |
| c. Long-Term Care: | | | | | | | |
| Long-Term Beds | 493 | 493 | 493 | 493 | | | |
| Long-Term ADC | 1,160 | 1,160 | 1,160 | 1,160 | | | |
| Long-Term Inpatients Treated | 3,606 | 3,606 | 3,606 | 3,606 | | | |
| **5. Number of Facilities:** | | | | | | | |
| VA Hospitals | 7 | 7 | 7 | 7 | | | |
| VA Nursing Home Care Units | 6 | 6 | 6 | 6 | | | |
| VA Domiciliaries | 0 | 0 | 0 | 0 | | | |
| Outpatient Clinics: | | | | | | | |
| Hospital Based, Independent & Mobile | 8 | 8 | 8 | 8 | | | |
| CBOCs, CBCs, Satellite & Outreach | 9 | 24 | 24 | 24 | | | |
| **6. Financial Measures (Medical Care):** | | | | | | | |
| a. Obligations Per Unique User Analysis (30% network goal): | | | | | | | |
| Obligations Per Unique User | $4,642 | $4,779 | $4,647 | $4,546 | $4,537 | $4,448 | $4,431 |
| Percent Change from 1997 Base | | 2.95% | 0.11% | -2.07% | -2.26% | -4.18% | -4.55% |
| Assumed Portion Current Services | | 3.75% | 7.63% | 11.63% | 15.45% | 19.92% | 24.28% |
| Percent Change Net of Current Services | | -0.80% | -7.52% | -13.70% | -17.71% | -24.10% | -28.83% |
| b. % Change in Unique Patient Users from 1997 base, from line 2a. above (20% network goal) | | 3.77% | 7.53% | 11.30% | 15.07% | 19.60% | 19.60% |
| c. % Revenues to Allocation + Revenues, from line 1b. above (10% network goal) | 0.00% | 3.68% | 4.41% | 5.60% | 8.50% | 10.21% | 9.87% |
| d. % of Acute Hosp.$s to Tot.of Acute $s + OP $s | 44.04% | 43.05% | 42.08% | 41.10% | | | |
| e. Outpatient Visits Per Unique User | 9.10 | 8.42 | 8.02 | 6.99 | | | |
| f. Med. Care Capital Obligations Per Unique User | $187 | $222 | $270 | $259 | | | |

# VA NORTHWEST NETWORK (NETWORK 20)
PLAN SUMMARY

## VISN OVERVIEW



The Network is comprised of the Pacific Northwest States of Washington, Oregon, the greater part of Idaho and all of Alaska. Its six medical centers, one independent domiciliary and one independent outpatient clinic served approximately 132,100 unique veterans in FY 1997. The majority of the veteran population is concentrated in the larger cities, e.g., Seattle and Portland, with a significant number residing in the rural counties as well. The estimated 1997 veteran population is 1,141,700. By the year 2002, the network expects to serve approximately 165,667 unique veterans or a 31 percent increase over FY 1997.

## PLAN HIGHLIGHTS

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| ***Quality*** | • Expand Provider Profiling reports to other than Primary Care Providers (e.g., Mental Health, Specialty, Sub-specialty)<br>• Publish a VISN 20 Quality Improvement Plan and complete a systematic evaluation of quality improvement activities within the network for FY 98, including actions to improve the Quality Improvement Plan<br>• Continue the development of the Consumer Health Information and Performance Set (CHIPS) project<br>• Implement a framework for the systematic identification, measurement and improvement of organizational and clinical processes and outcomes that most significantly impact patient care, resources, and organizational efficiency<br>• Provide analysis of measurement outcomes (Balanced Scorecard and Provider Profiling) to the Executive Leadership Council to assist in the identification, prioritization, and recommendation of improvement actions<br>• Measure functional status (SF 36) annually for all Network patients to provide health status data and to allow risk adjustment<br>• Monitor patient outcomes and resource use in ambulatory care, inpatient and long term care using FIM (Functional Independence Measures) |

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| ***Performance Measurement System*** | • Implement network responsibilities<br>• Establish a process for validating the data used in new measures within the Balanced Scorecard and CHIPS database at all network facilities<br>• Accomplish network initiatives<br>• Increase market penetration of Category A Users |
| ***Customer Service*** | • Implement a patient satisfaction instrument, based on the national outpatient survey<br>• Develop and implement an employee satisfaction instrument within the next year<br>• Implement initiatives designed to improve customer feedback and related information management systems |
| ***Primary Care/Case Management*** | • Collect case-mix adjusted data for primary care panels and make adjustments in the staffing and resources allocated to primary care<br>• Develop a coordinated network strategy in the areas of enrollment and contracting for primary care<br>• As in primary medical care, we have incorporated many managed care principles into the structure of our Mental Health programs. During FY98, we will further refine these practices and continue to implement these arrangements<br>• Anchorage: Establish case management support for urology and ophthalmology; augment ENT equipment<br>• Complete Minor construction to consolidate primary care services at Boise |
| ***Special Emphasis Programs and Six Disabling Conditions*** | • Implement alternative options for long-term care that provide quality service and customer satisfaction, and reduce overall costs in long term care<br>• Implement a Network Mental Illness Research, Education and Clinical Center (MIRECC) to study genetics and molecular biology, psycho-pharmacology and health services in post-traumatic stress disorders and schizophrenia<br>• Establish a VISN Homeless Services Advisory Group to ensure coordination of appropriate services for homeless veterans throughout the VISN<br>• Establish an integrated continuum of care for Spinal Cord Injury/Dysfunction patients<br>• Pilot test PTSD and substance abuse utilization review criteria<br>• Case management service may be expanded to include all TBI patients treated in the VISN |
| ***Community Based Outpatient Clinics (CBOCs)*** | • North King County/South Snohomish County, WA; Salem, OR; Tri-Cities, WA ; Bend, OR; Curry County, OR/Del Norte County, CA; Longview, WA; North Coast, OR/South Coast WA; Twin Falls, ID ('98)<br>• Bremerton/Kitsap County, WA; East Wenatchee, WA; Grants Pass, OR; Klamath Falls, OR; Lincoln City, OR; Moscow, ID/Pullman, WA; Olympia/South Thurston County, WA; The Dalles, OR; Yakima County, WA, also serving S. Kittitas County, WA ('99)<br>• Beaverton OR; Bellingham, WA; Gresham, OR; Lake Oswego, OR; Libby, MT ('00) |

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| ***Community Based Care Initiatives*** | • Implement community based outpatient care services in 22 locations (eight in 1998; nine in 1999; five in 2000) by the most cost-effective means<br>• Expand services to homeless veterans by supporting development of two proposals for the Grant and Per Diem Program by community based agencies |
| ***Improving Clinical and Administrative Information Systems*** | • Define funding requirements and implementation strategies for telemedicine at all facilities<br>• Expand telemedicine capabilities to provide useful solutions in cardiology, dermatology, neurology, and oncology (tumor board) and others areas<br>• Start the teleradiology and PACS project between the Portland and Vancouver campuses, effective with the minor improvement project to expand the Vancouver Outpatient Clinic in FY98 and evaluate the result |
| ***Communication*** | • Establish communication liaison with each of the major VISN 20 committees in order to facilitate and promote data driven decision-making<br>• Continue a contracting officer's mail group; a purchasing agent's mail group; monthly conference calls for contracting staff; monthly conference calls for purchasing agents; a weekly E-mail update to the A&MM chiefs; and conduct training/team building sessions for the contracting staff as required |
| ***Education*** | • Implement FY 1998-99 residency reduction assignments of August 1997 from VHQ and develop at least seven primary care residency positions<br>• Review and submit reports/recommendations on medical school academic affiliation reviews |
| ***Research*** | • Implement a Network Mental Illness Research, Education and Clinical Center (MIRECC) to study genetics and molecular biology, psychopharmacology and health services in post-traumatic stress disorders and schizophrenia<br>• Construction recently began on a research addition at VAMC Portland, which will add approximately 96,000 GSF in January 1999 |
| ***Sharing Agreements*** | • A VA/DOD Joint Venture Hospital is under construction and is scheduled for activation in the summer of 1998 at Elmendorf.<br>• VA/DOD sharing agreements with the Third Medical Group at Elmendorf Air Force Base and Bassett Army Community hospital permit sharing of resources and capabilities<br>• Boise VAMC has sharing agreements with Mt. Home Air Force Base, Indian Health Service, U.S. Forest Service, State of Idaho, Idaho State Veterans Home, and community health facilities as well as 92nd Medical Group at Fairchild Air Force Base<br>• Walla Walla VAMC has sharing agreements with two local community hospitals primarily for diagnostic support |

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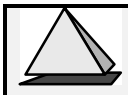
| ***Contracting Services*** | • Implement at least 75 percent of Community Based Outpatient Clinic (CBOC) proposals for FY 1998 – 2000 through contracts with the private sector<br>• Increase standardization of supplies, services and equipment to reduce duplication of inventories and provide one level of care throughout the network<br>• Hire an experienced private sector health care consultant to assist in development of the basic approach for contracted CBOCs<br>• Establish contracts/fee basis agreements for hand, ENT, ophthalmology, orthopedics, and gynecology care (Walla Walla)<br>• Determine whether contracted laboratory services can be performed cost effectively by Network facilities and recommend how to consolidate laboratory services within the Network<br>• Expand contracting for home health services<br>• Implement consolidated contracting to achieve discounts through bulk purchasing and competitive bidding: 1998 Contract Transcription, Hazardous Waste Disposal, Customer Service Training, Air Ambulance, 1999 Home IV Therapy, Home Oxygen, Durable Medical Equipment<br>• Engage in revenue enhancement projects to achieve the VHA goal of 10 percent of operating revenues from non-VA sources: laundry services; energy contracting; fuel tax refund<br>• Finalize a contract with Foundation Health Federal Services to serve CHAMPUS recipients |
| ***Managing Human Resources*** | • Establish partnership/consultative roles with various network groups to implement “just-in-time” training to resolve performance gaps and measure outcomes<br>• Plan/develop/implement a network-wide training program on "core competencies” in concert with the Cleveland Education Center; the program will be made available to all VA facilities<br>• The primary element in our strategy for achieving cost savings by utilization of physician extenders is the delivery of healthcare by a team of providers working together |
| ***Facility and/or Service Consolidations*** | • Consolidated procurements should be weighed in terms of cost effectiveness<br>• Provide locally at each network site a core set of surgical services to include general surgery, urology, ophthalmology, orthopedics, ENT, GYN and hand surgery<br>• During FY98, develop network-level contracts for home IV therapy and home oxygen, allowing other facilities to participate |


## NETWORK STRATEGIC PLAN SUMMARY

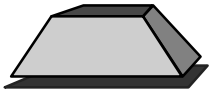


**Mission Goal:** Provide Healthcare to Enrolled Veterans Consistent with Benchmarks for Moderately Managed Care

**Operating Strategies**

**Develop a Group Practice Model and Mentality While Maintaining Integrated Governance and Shared Economic Incentives**

**Develop Network-Wide Steering Committees For Specific Patient Care Products, Principally Around Secondary Services, Where the Patient Is Dependent Upon a Coordinated Continuum of Care Produced by Multiple Organizational Elements**



**Performance Goals**

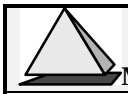
**'98:** Continue to ensure assignment of patients to primary care providers

**'98:** Primary care providers will authorize elective admissions and elective consultations for their patients

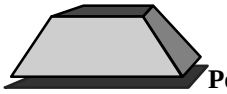
**'98:** Provide locally at each of the network practice sites a core set of surgical services to include general surgery, urology, ophthalmology, orthopedics, ENT, gynecology, and hand surgery

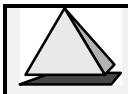
**'98:** Develop implementation plans to assure improved access to medical specialty services

**'98:** Develop an integrated information system and processes for management of patient flow among Oregon Alliance facilities

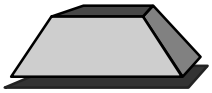


**Mission Goal:** Improve Service Access for Veterans and Reduce the Cost of Providing Health Benefits

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Design the Organization Around the Customer, Utilizing Integrated Primary Care Teams to Coordinate Care and Manage Resources.** | **'98:** Implement eight community based outpatient care services<br>**'98:** Define funding requirements and implementation strategies for telemedicine through guidance of clinical and telecommunication experts<br>**'98:** Determine whether contracted laboratory services can be performed cost effectively by network facilities and recommend how to consolidate laboratory services within the network |
| **Develop a Collaborative Vision of the Future and Communicate that Vision Throughout the Network, Fostering a Strong Cohesive Organizational Culture** | **'98:** Implement FY 1998-99 residency reduction assignments from VHQ (of August 1997) and develop at least seven primary care residency positions<br>**'98:** Review and submit reports/recommendations on medical school academic affiliations<br>**'98:** Implement alternatives for long term care that provide quality service and customer satisfaction and reduce overall costs<br>**'98:** Establish integrated continuum of care for spinal cord injury/dysfunction patients |



**Mission Goal:** Implement Operational Improvements that Result in Improved Patient Service and Reduced Costs

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Achieve economies of scale and eliminate redundancy through horizontal integration particularly of support functions** | **'98:** Solicit proposals from VISN facilities interested in being designated as the site for a centralized MCCF pre-registration program for the network. Establish a dedicated facility-based FTE to lead the network MCCF efforts<br>**'98:** Implement operational initiatives to reduce the recurring expenses associated with daily operations or to increase the efficiency and productivity of existing organizations<br>**'98:** Implement consolidated contracting to achieve discounts through bulk purchasing and competitive bidding |
| **Introduce internal market forces by separating purchaser and provider functions**. | **'98:** Engage in revenue enhancement projects to achieve the VHA goal of 10 percent of operating revenues from non-VA sources<br>• Implement at least 75 percent of Community Based Outpatient Clinic (CBOC) proposals through contracts with the private sector<br>• Finalize a contract with Foundation Health Federal Services to serve CHAMPUS recipients |

## 1997 SELECTED ACCOMPLISHMENTS

- Invested approximately $60,000 in case mix modeling and will invest another $240,000 this coming FY. Cost savings are anticipated in future years, as provider specific performance data becomes available
- Implemented the V-Tel system that resulted in: potential beneficiary travel savings; increased productivity for the dietitians who conduct the nutrition classes; the Bandon Clinic has experienced minimal no-shows for the nutrition classes; customers are very pleased that they do not need to travel to Roseburg to receive services; veterans seem more relaxed during their encounters
- Overall costs in the VISN for contract nursing home care were reduced while patients treated in alternative settings increased
- Inpatient BDOC/1000 has continued to decline and inpatient customer satisfaction scores have not been adversely impacted by these changes
- Presently, we have designated a primary care provider for approximately 60 percent of the veteran users in the VISN
- Data generated by the Northeast Program Evaluation Center (NEPEC) continues to suggest that the network leads the nation in terms of quality and cost-effectiveness (Mental Health)
- To date, approximately 14,000 patients have been assigned to a primary mental health provider
- The development of core mental health services at each facility enhances the quality of services provided to veterans
- The Utilization Management Advisory Group (UMAG) continues to work with the Quality Management Committee to ensure that utilization management data will be available through the CHIPS and, therefore, readily available to individual providers
- Ambulatory care issues are being addressed through the performance measures such as ambulatory surgical procedures as a percent of total procedures
- Very significant reduction in Bed Days of Care /1000 unique individuals for all facilities and the network as a whole
- Other notable improvements have been seen in the Chronic Disease and Prevention Index measures
- The proportion of Surgeries/Procedures completed on an outpatient basis increased, and operating beds were reduced to meet actual workload demands
- Developed Network Performance and Quality Improvement Plan
- Network Education Council held monthly video-teleconferences on principles of managed care
- Chief RMS at Portland completed capability analysis for all facilities and made recommendations on how to move to an integrated continuum of care for SCI patients
- Adapted 15 prevention and screening guidelines
- Accomplished 22 consolidated contracts and eight special pricing agreements within the network

***Information as of December 12, 1997. The financial and workload information presented in this package is currently under review for use in budget justifications submitted to Congress.***

**BUDGETARY DATA SET (VISN 20)** **Table B-1**

| | 1997 Base | 1998 Tactical | 1999 Strategic | 2000 Strategic | 2001 Target | 2002 Target | 2003 Target |
|---|---|---|---|---|---|---|---|
| **1. Financial ($'s in thousands):** | | | | | | | |
| a. Medical Care, Sources of Funding: | | | | | | | |
| VERA Allocation for Medical Care | $621,737 | $648,455 | $665,659 | $672,711 | $672,711 | $672,711 | $672,711 |
| MCCR Collection [See Note] | $0 | $18,740 | $23,040 | $26,899 | $31,017 | $35,180 | $39,530 |
| Medicare Reimbursement | $0 | $0 | $0 | $0 | $0 | $29,200 | $29,200 |
| Tricare Collection | $0 | $100 | $150 | $200 | $300 | $400 | $500 |
| Other Sharing/Reimbursements | $5,000 | $6,000 | $7,000 | $8,000 | $9,000 | $10,000 | $11,000 |
| Planned Unobligated Balances | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Total = Allocation + Revenues** | $626,737 | $673,295 | $695,849 | $707,810 | $713,028 | $747,491 | $752,941 |
| b. Percent Revenues to Allocation + Revenues | 0.80% | 3.69% | 4.34% | 4.96% | 5.65% | 10.00% | 10.66% |
| c. Distribution of Funding by selected activities: | | | | | | | |
| Acute Hospital Care | $241,544 | $241,544 | $241,544 | $241,544 | | | |
| Outpatient Care | $237,408 | $283,184 | $308,546 | $321,207 | | | |
| Long-Term Care | $96,517 | $104,084 | $106,694 | $108,549 | | | |
| Total | $575,469 | $628,812 | $656,784 | $671,300 | | | |
| **2. Federal Employment:** | | | | | | | |
| Average Employment (FTE), Total | 6,977 | 7,058 | 7,043 | 6,920 | | | |
| **3. Unique Patient Users (PRPs): [Unduplicated at the National Level]** | | | | | | | |
| a. Total Unique Patient Users (PRPs) | 126,801 | 134,000 | 141,000 | 149,100 | 154,300 | 165,667 | 165,700 |
| Percent Increase/Decrease from 1997 Base | | 5.68% | 11.20% | 17.59% | 21.69% | 30.65% | 30.68% |
| b. Distribution of PRPs by Eligibility Category: | | | | | | | |
| Category A | 111,534 | 117,866 | 124,023 | 131,148 | | | |
| Category C | 3,018 | 3,190 | 3,356 | 3,549 | | | |
| Non-Veteran Users | 12,249 | 12,944 | 13,621 | 14,403 | | | |
| Total | 126,801 | 134,000 | 141,000 | 149,100 | | | |
| c. Distribution of PRPs by VERA Patient Groups: | | | | | | | |
| Special Care Unique Patient Users | 48,184 | 50,920 | 53,580 | 56,658 | | | |
| Basic Care Unique Patient Users | 78,617 | 83,080 | 87,420 | 92,442 | | | |
| Total | 126,801 | 134,000 | 141,000 | 149,100 | | | |
| **4. Workload Episodes:** | | | | | | | |
| a. Outpatient Visits (Staff & Fee) | 1,328,109 | 1,399,116 | 1,459,145 | 1,510,771 | | | |
| b. Acute Hospital Care: | | | | | | | |
| Acute Hospital Beds | 579 | 576 | 564 | 546 | | | |
| Acute Hospital ADC | 509 | 506 | 496 | 480 | | | |
| Acute Inpatients Treated | 25,403 | 25,847 | 25,955 | 25,759 | | | |
| c. Long-Term Care: | | | | | | | |
| Long-Term Beds | 2,238 | 2,357 | 2,458 | 2,545 | | | |
| Long-Term ADC | 2,207 | 2,324 | 2,424 | 2,509 | | | |
| Long-Term Inpatients Treated | 6,394 | 6,732 | 7,021 | 7,269 | | | |
| **5. Number of Facilities:** | | | | | | | |
| VA Hospitals | 6 | 6 | 6 | 6 | | | |
| VA Nursing Home Care Units | 6 | 6 | 6 | 6 | | | |
| VA Domiciliaries | 4 | 4 | 4 | 4 | | | |
| Outpatient Clinics: | | | | | | | |
| Hospital Based, Independent & Mobile | 20 | 20 | 20 | 20 | | | |
| CBOCs, CBCs, Satellite & Outreach | 6 | 14 | 23 | 29 | | | |
| **6. Financial Measures (Medical Care):** | | | | | | | |
| a. Obligations Per Unique User Analysis (30% network goal): | | | | | | | |
| Obligations Per Unique User | $4,943 | $5,025 | $4,935 | $4,747 | $4,621 | $4,512 | $4,544 |
| Percent Change from 1997 Base | | 1.66% | -0.16% | -3.97% | -6.51% | -8.72% | -8.07% |
| Assumed Portion Current Services | | 3.75% | 7.63% | 11.63% | 15.45% | 19.92% | 24.28% |
| Percent Change Net of Current Services | | -2.09% | -7.79% | -15.60% | -21.96% | -28.64% | -32.35% |
| b. % Change in Unique Patient Users from 1997 base, from line 2a. above (20% network goal) | | 5.68% | 11.20% | 17.59% | 21.69% | 30.65% | 30.68% |
| c. % Revenues to Allocation + Revenues, from line 1b. above (10% network goal) | 0.80% | 3.69% | 4.34% | 4.96% | 5.65% | 10.00% | 10.66% |
| d. % of Acute Hosp.$s to Tot.of Acute $s + OP $s | 50.43% | 46.03% | 43.91% | 42.92% | | | |
| e. Outpatient Visits Per Unique User | 10.47 | 10.44 | 10.35 | 10.13 | | | |
| f. Med. Care Capital Obligations Per Unique User | $328 | $342 | $319 | $314 | | | |

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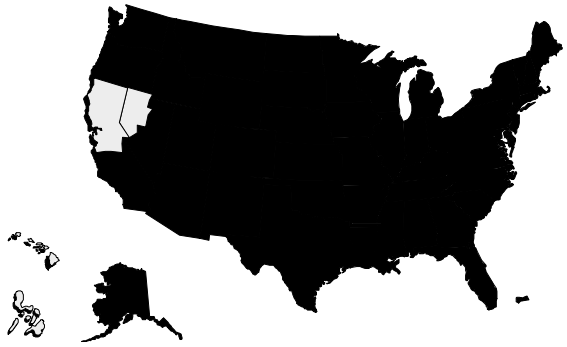
# VA SIERRA PACIFIC NETWORK (NETWORK 21)
PLAN SUMMARY

## VISN OVERVIEW



The VA Sierra Pacific Network is a large and geographically diverse region. The network spans 240,000 square miles and includes Hawaii and parts of California and Nevada. In addition, several Pacific Islands (e.g., American Samoa, Commonwealth of the Northern Mariana Islands and Republic of Palau) and the Philippines are part of the network. The network veteran population, currently more than 540,000 veterans, falls into six separate market areas: North San Francisco Bay Area, South San Francisco Bay Area, Sacramento Valley, Central Valley, Sierra Nevada and Pacific Basin. Three markets (North San Francisco Bay, South San Francisco Bay and Sacramento Valley) operate facilities in close proximity to each other and share many patients. Many markets in this network have also been influenced by the closure of military bases. This has created the opportunity for VA to provide services to the 300,000 DOD beneficiaries in the network and acquire healthcare facilities being vacated by DOD.

## PLAN HIGHLIGHTS

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|---|---|
| ***Quality*** | • Continue to identify and implement clinical guidelines that are consistent with quality of care and delivery standards<br>• Invest in equipment to improve the quality of care<br>• Invest in capital maintenance to improve quality of care<br>• Obtain at least one Clinical Center of Excellence designation<br>• Begin preparation for future National Commission on Quality Assurance surveys |
| ***Performance Measurement System*** | • Evaluate the establishment of six management positions (Chief Officers) for medical care, finance, operations, information, performance improvement, and marketing<br>• Monitor network performance as identified by approximately 40 network performance measures established to achieve Eight for '98<br>• Further develop the Sierra Pacific Network "Balanced Scorecard" |
| ***Customer Service*** | • Know and follow the policies, procedures, and customer service principles to ensure patient safety and customer satisfaction<br>• Improve communication to customers by distributing network newsletter and direct mailing when appropriate<br>• Ensure proposed capital expenditures support improved performance levels in customer access and satisfaction, and an increase in users |

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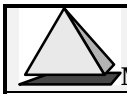
|---|---|
| ***Primary Care/Case Management*** | • All network facilities have established primary care providers as the point of entry into the network's healthcare system<br>• Activate primary care services at two or more Vet Centers<br>• Increase Home-Based Primary Care programs and services in each market<br>• Begin primary care profiling<br>• Implement panel size recommendations developed by Primary Care Service Line<br>• Standardize primary care encounter form and capture of preventive health measures<br>• Increase primary care enrollment to ≥ 90 percent (based on CSS) in FY98<br>• Ensure improved access to already enrolled veterans and potential enrollees |
| ***Special Emphasis Programs and Six Disabling Conditions*** | • Obtain training for CARF accreditation and coordinate surveys to ensure all markets will be surveyed in the same calendar year<br>• Administer short version of Addiction Severity Index (ASI) to all patients with primary or secondary diagnosis of substance abuse<br>• Implement at least two clinical practice guidelines in the areas of mental health and long term care<br>• Obtain Clinical Center of Excellence designation for services to homeless veterans<br>• Obtain CARF accreditation at two facilities<br>• Provide psychiatric services at (or in close collaboration with) two or more Vet Centers |
| ***Community Based Outpatient Clinics (CBOCs)*** | • Locations: Auburn, CA, and Merced, CA, submitted for approval<br>• Activate or enhance clinics in Auburn, CA; Vallejo, CA; Chico, CA; Eureka, CA; Merced, CA; Modesto, CA; Visalia, CA<br>• Develop a five year plan for location of CBOCs<br>• 13 future sites are identified based on demographics of the veteran population and projected utilization |
| ***Community Based Care Initiatives*** | • Contract for inpatient services with community hospitals in Redding and Martinez<br>• Partner or contract with community providers in remote areas not currently served by VA facilities |
| ***Service Lines*** | • Long Term /Extended Care Service Line is currently focused on the development of a clinical inventory and standard admission and utilization review criteria |
| ***Improving Clinical and Administrative Information Systems*** | • Implement the Computerized Patient Record System (CPRS)<br>• Develop DSS mapping changes with the aid of the new network-wide Nurse Scheduler Package to enhance nurse staffing costing within the DSS software<br>• Develop PC-based video-teleconferencing throughout the network<br>• Develop Phase I of a network-wide Image Management System for storage and transmission of digital images at each facility |

| | |
|---|---|
| ***Communication*** | • Improve the image and perceptions of VA by increasing community involvement and more effectively utilizing media (print and broadcast)<br>• Improve linkages and communication with Veterans Benefits Administration<br>• Improve communication to customers by distributing network newsletter and direct mailing when appropriate |
| ***Research*** | • Develop a plan in each market to retain indirect costs of research<br>• Revise and resubmit proposal to obtain Mental Illness Research, Education and Clinical Center (MIRECC) designation<br>• Increase research revenues and explore consolidating research administrative functions<br>• Encourage closer alignment of research, training, and special programs |
| ***Education*** | • Strengthen affiliations with academic institutions<br>• Achieve survey results indicating that at least 90 percent of residents regard their VA educational and training experience to be very good or excellent |
| ***Sharing Agreements*** | • Collect an additional $200,000 in sharing and enhanced use agreements in FY 98 compared to FY 97<br>• Develop at least one additional enhanced use sharing agreement within each market<br>• Expand DOD sharing agreements for inpatient, outpatient, and dental care, for veterans, military personnel, and recent retirees (i.e., Tripler AMC in Hawaii, Travis AFB in No. California, Fallon NAS in Nevada)<br>• Explore possible service consolidations and resource sharing opportunities |
| ***Contracting Services*** | • Implement consolidated contracting initiative in FY 1998<br>• Explore additional care options for veterans through contracting arrangements with non-federal entities such as state and local governments and private industry<br>• Contract with programs such as the On Lok program in San Francisco to provide a full continuum of care to geriatric veterans who need nursing home level of care in a more cost-effective manner |
| ***Managing Human Resources*** | • Shift manpower resources to assist in the development of nurse case management and/or nurse run primary care clinics<br>• Continue to use certified nurse specialists, advanced practice RNs, nurse practitioners and physician assistants for pre-operative evaluations, health screenings, and mental health screening<br>• Implement case management protocols throughout the network |
| ***Facility and/or Service Consolidations*** | • Explore possible service consolidations and resource sharing opportunities<br>• Streamline clinical services by re-engineering certain clinical activities. Highly specialized, low-volume, high cost and geographically redundant services will be scrutinized<br>• Further develop network clinical and administrative product lines established to serve as a forum for the development of inter-facility relationships, and a mechanism to standardize and centralize services as appropriate |
| ***Emergency Preparedness*** | • Continue the network's emergency communication system and the work of the network's Emergency Medical Preparedness Advisory Council |

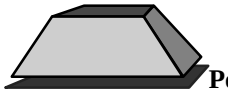

## NETWORK STRATEGIC PLAN SUMMARY

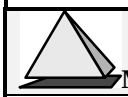
**Mission Goal:** Increase the Number of Veterans Who Use VA Services

| Operating Strategies | Performance Goals |
|---|---|
| **Increase Unique Category A Users by 5.0 percent in 1998, Compared to FY 97** | • Form a network Marketing Council and charter this group to develop a network-wide marketing plan<br>• Develop and implement marketing strategies designed to better inform veterans of available services (e.g., direct mailings, newsletters, Internet Web pages and public service announcements)<br>• Intensify outreach activities (e.g., health fairs, screening clinics, mobile van clinics, stand-down events and visits to homeless shelters) within each market area |
| **Increase the 3-Year Average (FY 96/97/98) of Total Basic and Special Category Patients by 4.0%, Compared to FY 95/96/97** | • Implement the FY 97 New Member Services initiative and simplify new patient registration<br>• Improve the image and perceptions of VA by increasing community involvement and more effectively utilizing media (print and broadcast)<br>• Request Health Services Research and Development to determine the reasons why veterans leave the VA healthcare system |

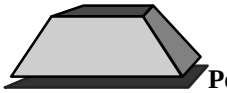


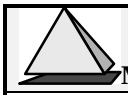
**Mission Goal:** Improve Access to Clinical Services

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Overcome Geographic Barriers** | • Develop a five-year plan for location of CBOCs<br>• Activate CBOCs or significantly enhance existing services in at least four of the following locations in California: Auburn, Chico, Eureka, Merced, Modesto, Vallejo and Visalia<br>• Increase Home-Based Primary Care programs and services in each market<br>• Overcome poor access to inpatient care<br>• Partner or contract with community providers in remote areas not currently served by VA facilities<br>• Include network-wide participants in the planning and activation of VA inpatient beds in Sacramento<br>• Expand use of traveling consultants and telemedicine throughout the network |

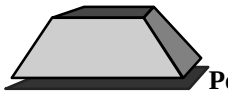


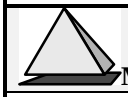
**Mission Goal:** Improve and Demonstrate High Quality Care

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Commit to Providing the Best Possible Services** | • Improve quality of care and achieve survey results indicating the proportion of patients who report their overall VA healthcare services as very good to excellent to be at least 90 percent<br>• Improve Chronic Disease Index (CDI) score to 85 percent<br>• Improve Prevention Index (PI) score to 70 percent<br>• Provide national leadership in risk management and clinical practice guidelines<br>• Demonstrate an outstanding level of achievement in the FY 98 national performance measure relating to CPGs<br>• Establish network registry for sentinel events |

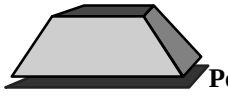


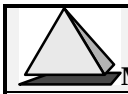
**Mission Goal:** Increase External Revenues

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Improve Revenue Collection Procedures** | • Ensure accurate third-party payor information on encounter forms<br>• Reorganize and increase training for MCCR staff to improve efficiencies and increase collections<br>• Complete TriCare training within each market<br>• Identify Medicare eligible patients within our current database |
| **Improve Marketing of VA Services** | • Promote VA service options to TriCare beneficiaries in the San Francisco Bay Area and Sacramento Valley markets<br>• Develop at least one additional enhanced use sharing agreement within each market |

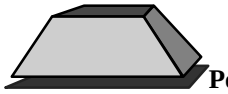


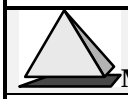
**Mission Goal:** Improve Customer Satisfaction

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Make Customer Satisfaction one of Sierra Pacific Network's Highest Priorities** | • Improve customer satisfaction and achieve survey results indicating that the proportion of patients who report their overall VA healthcare services as very good to excellent to be at least 90 percent<br>• Achieve survey results indicating the average number of Customer Service Standard (CSS) problems (i.e., index) reported per network patient is $\leq 0.2$<br>• Reduce the number of patients who leave by 20 percent in FY 98<br>• Develop and administer network and local surveys to complement national efforts and provide more timely and frequent feedback<br>• Charge the Marketing Council to analyze results of surveys and focus groups, identify significant causes of customer dissatisfaction and propose remedies<br>• Develop and share "lessons learned" about techniques and mechanisms to improve customer service and satisfaction |

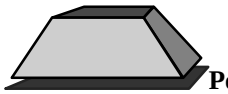


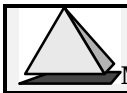
**Mission Goal:** Enhance Special Programs

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Emphasize Meeting the Unique Needs of the Special Veteran Populations** | • Revise and implement the Extended Care Strategic Plan<br>• Strengthen Gulf War programs through the implementation of recommendations from the Service Evaluation and Action Team (SEAT)<br>• Charge Mental Health Service Line to revise and resubmit the MIRECC proposal<br>• Develop functional status and other outcome measures for selected special programs |

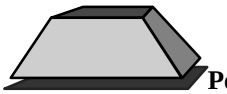


**Mission Goal:** Increase the Knowledge of Staff and Customers

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Emphasize New VHA Patient Care Culture in Academic Training Programs** | • Review resident evaluation forms and survey residents regarding their satisfaction with VA education and training<br>• Collaborate with academic affiliates to ensure that research funded by VA and conducted by VA staff will contribute to VHA and network missions<br>• Achieve survey results indicating that at least 90 percent of residents regard their VA educational and training experience to be very good or excellent |
| **Emphasize Employee Education and Training** | • Provide and document 20 hours of education and training in the area of quality improvement for at least 50 percent of all full-time employees<br>• Partner with Employee Education System (EES), VHA Headquarters and other networks to develop employee education and documentation tools<br>• Enhance video-conferencing capabilities, including PC-based systems |



**Mission Goal:** Improve the Efficiencies of Clinical and Business Operations

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Implement Managed Care Clinical Practices** | • Reduce acute bed days of care (BDOC) per 1,000 patients to 1,400 (i.e., 2.5 percent decrease compared to FY 97)<br>• Exceed the national VHA level of performance in ambulatory surgery<br>• Implement care-management programs in each market area |
| **Exploit Economies of Scale in Managing Network Operations** | • Analyze results from the Resource Value Unit (RVU) pilot at VAMC San Francisco and propose network-wide recommendations<br>• Revise network internal resource allocation methodology for FY 99<br>• Explore possible service consolidations and resource sharing opportunities |

## 1997 SELECTED ACCOMPLISHMENTS

- Formed network Education Committee to coordinate educational activities and disseminate new knowledge
- Reallocated residency positions consistent with national priorities and healthcare needs. The network added 7.4 primary care positions, decreased 11.4 specialty care positions and eliminated 4.0 residency positions
- Established network Quality Management Committee, which coordinated nine Joint Commission on Accreditation of Healthcare Organizations training sessions in the areas of long-term and sub-acute care, hospital care, mental health and root cause analysis
- Obtained an independent Community-Based Outpatient Clinics (CBOCs) analysis of potential locations, which prioritized 13 future sites (based on demographics of the veteran population and projected utilization rates)
- Activated three outpatient clinics to expand basic healthcare services; submitted two additional proposals for FY98 activation
- Established the Comprehensive Homeless Center (CHC) in San Francisco, which is dedicated to providing a continuum of healthcare services to homeless veterans
- Conducted outreach activities and health fairs to educate veterans and communities about VA medical services
- Established Centralized After Hours Telephone Care to provide emergency referrals, routine medical advice and eligibility information after 4:30 p.m. and on weekends
- Received National Disaster Medical System Certificate of Outstanding Achievement
- Piloted 14 network-wide Clinical Practice Guidelines and provided training for implementation
- Designed an Adverse Outcomes Database that will include a network sentinel events registry
- Established TriCare contracts in all network markets
- Negotiated a preferred provider contract with Blue Cross
- Sold service's excess capacity to community healthcare organizations
- Established a network Spinal Cord Injury Center (SCIC) Marketing Committee. The Committee developed a brochure describing the eligibility and scope of services offered at the SCIC. This brochure was mailed to selected veterans, VA facility discharge planners and care managers
- Conducted outreach efforts to blind veterans and established support groups for blind veterans in State Veteran Homes
- Purchased customer satisfaction survey tool (i.e., Corporate Plus Program) to create employee, patient and provider specific surveys
- Formed a Service Evaluation Action Team to address issues relating to Persian Gulf veterans
- Implemented customer service training within each market area
- Developed innovative method for allocating Veterans Equitable Resource Allocation (VERA) resources within the network
- Determined network formulary and prepared for national formulary
- Established Lab Management Board to identify efficiencies in laboratory and pathology services
- Developed uniform primary care encounter form for all Network facilities
- Established consistent extended care admission and discharge criteria
- Published Cardiac Care Services Directory and developed a uniform patient referral process
- Established Network Emergency Communications System
- Established Network Emergency Medical Preparedness Advisory Council

***Information as of December 12, 1997. The financial and workload information presented in this package is currently under review for use in budget justifications submitted to Congress.***

**BUDGETARY DATA SET (VISN 21)** **Table B-1**

| | 1997 Base | 1998 Tactical | 1999 Strategic | 2000 Strategic | 2001 Target | 2002 Target | 2003 Target |
|---|---|---|---|---|---|---|---|
| **1. Financial ($'s in thousands):** | | | | | | | |
| a. Medical Care, Sources of Funding: | | | | | | | |
| VERA Allocation for Medical Care | $720,472 | $726,755 | $726,755 | $726,755 | $726,755 | $726,755 | $726,755 |
| MCCR Collection [See Note] | $0 | $15,943 | $18,530 | $21,250 | $23,971 | $26,765 | $28,250 |
| Medicare Reimbursement | $0 | $0 | $0 | $5,000 | $30,000 | $47,400 | $58,000 |
| Tricare Collection | $240 | $330 | $359 | $500 | $677 | $800 | $900 |
| Other Sharing/Reimbursements | $2,109 | $2,317 | $3,100 | $4,550 | $5,100 | $5,750 | $6,100 |
| Planned Unobligated Balances | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| **Total = Allocation + Revenues** | $722,821 | $745,345 | $748,744 | $758,055 | $786,503 | $807,470 | $820,005 |
| b. Percent Revenues to Allocation + Revenues | 0.32% | 2.49% | 2.94% | 4.13% | 7.60% | 10.00% | 11.37% |
| c. Distribution of Funding by selected activities: | | | | | | | |
| Acute Hospital Care | $128,575 | $130,058 | $131,800 | $132,750 | | | |
| Outpatient Care | $216,511 | $220,198 | $223,327 | $225,197 | | | |
| Long-Term Care | $72,354 | $73,198 | $74,778 | $75,578 | | | |
| Total | $417,440 | $423,454 | $429,905 | $433,525 | | | |
| **2. Federal Employment:** | | | | | | | |
| Average Employment (FTE), Total | 7,635 | 7,620 | 7,610 | 7,590 | | | |
| **3. Unique Patient Users (PRPs): [Unduplicated at the National Level]** | | | | | | | |
| a. Total Unique Patient Users (PRPs) | 124,344 | 130,800 | 136,780 | 142,400 | 147,990 | 154,480 | 158,200 |
| Percent Increase/Decrease from 1997 Base | | 5.19% | 10.00% | 14.52% | 19.02% | 24.24% | 27.23% |
| b. Distribution of PRPs by Eligibility Category: | | | | | | | |
| Category A | 102,335 | 108,145 | 113,527 | 118,585 | | | |
| Category C | 7,217 | 6,404 | 6,069 | 5,915 | | | |
| Non-Veteran Users | 14,792 | 16,251 | 17,184 | 17,900 | | | |
| Total | 124,344 | 130,800 | 136,780 | 142,400 | | | |
| c. Distribution of PRPs by VERA Patient Groups: | | | | | | | |
| Special Care Unique Patient Users | 6,218 | 6,423 | 6,619 | 6,808 | | | |
| Basic Care Unique Patient Users | 118,126 | 124,377 | 130,161 | 135,592 | | | |
| Total | 124,344 | 130,800 | 136,780 | 142,400 | | | |
| **4. Workload Episodes:** | | | | | | | |
| a. Outpatient Visits (Staff & Fee) | 1,487,948 | 1,530,360 | 1,572,970 | 1,609,120 | | | |
| b. Acute Hospital Care: | | | | | | | |
| Acute Hospital Beds | 446 | 446 | 426 | 406 | | | |
| Acute Hospital ADC | 330 | 324 | 304 | 284 | | | |
| Acute Inpatients Treated | 17,313 | 17,666 | 18,288 | 18,823 | | | |
| c. Long-Term Care: | | | | | | | |
| Long-Term Beds | 798 | 798 | 798 | 798 | | | |
| Long-Term ADC | 1,808 | 1,856 | 1,884 | 1,933 | | | |
| Long-Term Inpatients Treated | 6,117 | 6,278 | 6,430 | 6,550 | | | |
| **5. Number of Facilities:** | | | | | | | |
| VA Hospitals | 6 | 6 | 6 | 6 | | | |
| VA Nursing Home Care Units | 6 | 6 | 6 | 6 | | | |
| VA Domiciliaries | 1 | 1 | 1 | 1 | | | |
| Outpatient Clinics: | | | | | | | |
| Hospital Based, Independent & Mobile | 7 | 7 | 7 | 7 | | | |
| CBOCs, CBCs, Satellite & Outreach | 33 | 37 | 39 | 41 | | | |
| **6. Financial Measures (Medical Care):** | | | | | | | |
| a. Obligations Per Unique User Analysis (30% network goal): | | | | | | | |
| Obligations Per Unique User | $5,813 | $5,698 | $5,474 | $5,323 | $5,315 | $5,227 | $5,183 |
| Percent Change from 1997 Base | | -1.98% | -5.83% | -8.43% | -8.57% | -10.08% | -10.84% |
| Assumed Portion Current Services | | 3.00% | 6.30% | 10.00% | 14.80% | 19.92% | 24.28% |
| Percent Change Net of Current Services | | -4.98% | -12.13% | -18.43% | -23.37% | -30.00% | -35.12% |
| b. % Change in Unique Patient Users from 1997 base, from line 2a. above (20% network goal) | | 5.19% | 10.00% | 14.52% | 19.02% | 24.24% | 27.23% |
| c. % Revenues to Allocation + Revenues, from line 1b. above (10% network goal) | 0.32% | 2.49% | 2.94% | 4.13% | 7.60% | 10.00% | 11.37% |
| d. % of Acute Hosp.$s to Tot.of Acute $s + OP $s | 37.26% | 37.13% | 37.11% | 37.09% | | | |
| e. Outpatient Visits Per Unique User | 11.97 | 11.70 | 11.50 | 11.30 | | | |
| f. Med. Care Capital Obligations Per Unique User | $371 | $286 | $278 | $251 | | | |

# VA DESERT PACIFIC HEALTHCARE NETWORK (NETWORK 22)
PLAN SUMMARY

## VISN OVERVIEW

The Network spans about 110,000 square miles of southern California and southern Nevada. The Network contains three of the nation's most heavily populated counties, yet many parts are uninhabited desert and mountain areas. Nevada is the nation's 7th largest state, and is divided into two parts, with 80 percent of the population in the southern part. The area's estimated veteran population is 1,714,500.

## PLAN HIGHLIGHTS

| | |
|---|---|
| ***Quality*** | • Foster use of 19 clinical practice guidelines to ensure appropriate and quality healthcare delivery in these areas<br>• Work on decreasing average length of stay<br>• Identify necessary knowledge, skills, and behaviors needed to support PI (performance improvement) at network and facility levels<br>• Identify best practices in current/ongoing PI support activities at unit and corporate levels<br>• Identify outcomes-based strategy for PI within VISN<br>• Achieve new accreditations - CARF and Network-wide JCAHO |
| ***Performance Measurement System*** | • Develop and implement VISN training plan for JCAHO accreditation<br>• Develop and implement VISN preparation plan for JCAHO accreditation as a network<br>• Pilot PI models and assess degree of improvement in local team performance<br>• Develop a list of key performance indicators<br>• Develop valid and reliable tracking tools by defining the scope of performance tracking tasks and responsibilities (3/98)<br>• Develop a model and reporting mechanism for performance tracking (4/98)<br>• Identify external sources of relevant data and methodology for assessing and communicating findings (7/98) Establish provider-specific performance tracking (7/98)<br>• Identify data validation plan(s)(2/98) |

| | |
|---|---|
| ***Customer Service*** | • Develop plan for providing training network-wide (2/98)<br>• Implement and manage the training plan<br>• Patient/Customer Service Program initiatives will be formulated based on best practice initiatives in the healthcare industry (12/97) |
| ***Primary Care/Case Management*** | • Ensure that all clinicians at Primary Care sites have admitting privileges at Network hospitals<br>• Complete minor construction (Phase II), ambulatory surgery, at San Diego<br>• Complete minor construction to remodel specialty clinics at Loma Linda |
| ***Special Emphasis Programs and Six Disabling Conditions*** | • Veterans in these sub-populations will receive the full, appropriate continuum of care. Patients will be enrolled, as needed, under the new VA Healthcare Enrollment System<br>• Patients will be assigned to the primary care provider/team, or specialist provider/team, as appropriate for their total healthcare needs, including efforts to maximize functionality, disease prevention and wellness |
| ***Community Based Outpatient Clinics (CBOCs)*** | • Approved: Las Vegas, Henderson, Santa Ana, Anaheim, Chula Vista, Lancaster ('98)<br>• Approved: Oxnard, San Luis Obispo, Lompoc; Proposed: Hollywood, Culver City ('98)<br>• Planned: Las Vegas-Northwest, Mesquite, Hemet, Palm Springs/Indio, West Riverside, San Bernardino, Irvine, Laguna Niguel, Pasadena, West Covina, Whittier, Inglewood, Mobile Van ('99-'10) |
| ***Community Based Care Initiatives*** | • Vet Center/V22 collaborations include co-locations of CBOCs with Vet Centers. The Gardena site is operational and future plans include co-locations in Anaheim, Culver City and Vista. V22 will explore with Vet Centers the potential for providing tele-medicine at co-located sites<br>• In California, co-location of a CBOC with the new Chula Vista State Veterans Home (under construction) will be pursued<br>• In Nevada, a new State Veterans Home will begin construction at Nellis Air Force Base in Las Vegas. VHA will provide the on-site primary care for this facility |
| ***Service Lines*** | • The Network's Business Center is planned to be fully staffed in FY98 thus saving considerable medical salary dollars to be redirected to other patient care activities |
| ***Improving Clinical and Administrative Information Systems*** | • Complete the investment in clinical workstations to activate clinicians' charting locations<br>• Invest in new workstations for administrative purposes<br>• Accomplish much of the TIP work during FY98-99<br>• Activate Hub electronics purchased in FY97 during FY98 |

| | |
|---|---|
| ***Communication*** | • Implement a communication improvement plan (4/98)<br>• Implement a public relations improvement plan (4/98)<br>• Implement marketing improvement plan (4/98)<br>• Develop protocols for exchanging information among VISN elements (6/98)<br>• Identify and assess external agencies as possible sources of advertising, public relations and marketing (2/98)<br>• Develop and implement training program for facility staff involved in public relations, marketing and related activities (3/98) |
| ***Education*** | • Develop and implement plan to provide PI training and consultation<br>• Design and establish work group to facilitate PI education and support<br>• Assess current facility-based training programs (12/97) |
| ***Sharing Agreements*** | • Military: Loma Linda - U. S. Army, Fort Irwin (8/97-8/98); West Los Angeles - Marine Corps Air Reserve Group (pending); Long Beach - U.S. Army National Guard; U.S. Army, Los Alamitos (pending); U.S. Army Reserve Unit (pending); U.S. Navy, Seal Beach (pending)<br>• DOD Specialized Treatment Services (STS) Program - two designated STS sites for cardiothoracic surgery at San Diego and West Los Angeles. The Network is reviewing a suggestion by the UC, San Diego, concerning a joint proposal to DOD for all 20 of the Diagnosis Related Groups in the STS program |
| ***Contracting*** | • Offer a full continuum of services with organ transplantation available through fee-for-service arrangement with private sector partners<br>• Bureau of Prisons - So. Calif. System of Clinics has an ongoing program. West Los Angeles provides psychology services<br>• U.S. Public Health Service - Long Beach is renewing its medical/dental contract with the U. S. Federal Penitentiary, Terminal Island<br>• CHAMPVA - Ongoing programs exist at Loma Linda, West Los Angeles, and the LAOPC<br>• Medical/Surgical Contracts: Loma Linda - Contract effective May 1, 1997. 80 Prime patients enrolled at VAMC in first 4 ½ months.<br>• U.S. Coast Guard - ongoing programs continue at Long Beach and Loma Linda<br>• Mental Health Contracts: Las Vegas: VISN 22 has been contacted by Managed Health Net, Inc., concerning participation in Foundation's mental health program in Southern California |
| ***Facility and/or Service Consolidations*** | • Assessing the feasibility of integrating VAMC West Los Angeles with the Southern California System of Clinics (SCSC)(formerly, VAMC Sepulveda, Los Angeles Outpatient Clinic, and Satellite Outpatient Clinics at Bakersfield and Santa Barbara)<br>• Purchases/upgrades equipment at: Loma Linda — Cardiac Cath Lab; Long Beach — lithotriptor; West LA — MRI, linear accelerator, PET Scanner, CT Scanner |
| ***Emergency Preparedness*** | • Four medical centers are designated as primary Receiving Centers for VA/DOD contingency activations |


## NETWORK STRATEGIC PLAN SUMMARY

**Mission Goal:** Decrease the VHA-wide Average Cost (Expenditure per Patient) by 30%

| Operating Strategies | Performance Goals |
|---|---|
| **Improve Access to Care** | **'98:** Implement PACS and Tele-radiology - install computed radiography<br>**'00:** Implement PACS and Tele-radiology - full filmless interpretation and storage<br>**'98:** Expand Phone Care program to 24 hours Network-wide |
| **Decrease Acute Inpatient Use (Average Length of Stay)** | **'98-00:** Reduce average length of stay by one day |
| **Increase Primary Care** | **'98:** Increase primary care to 90 percent |
| **Expand Nurse-Managed Care** | **'98:** Increase by 10 percent<br>**'99:** Increase by 10 percent<br>**'00:** Increase by 10 percent |
| **Improve Organizational Performance** | **'98:** Fully staff Network Business Center<br>**'98:** Save $2 million via consolidated buying<br>**'99:** Save $2 million via consolidated buying<br>**'99:** Save $2 million in salary cost<br>**'00:** Save $2 million in salary cost |
| **Build Informatics Infrastructure** | **'98:** Improve Electronic Communication<br>Fully implement MS Exchange<br>Develop VISN Intranet<br>Fully implement PC networking<br>**'98:** Complete TIP initiative; implement clinical workstations<br>**'00:** Technology Life Cycle replacement |

| | | |
|---|---|---|
| **Implement VISN-Wide Electronic Record** | **'98:** | Implement CPRS at VISN key site (WLA) |
| | **'99:** | Implement CPRS VISN-wide |
| | **'00:** | Implement Clinical Repository |
| | **'98:** | Implement Year 2000 Plan |
| | **'99:** | Complete Year 2000 Plan |
| **Enhance Data-Driven Decision-Making** | **'98:** | Improve Ambulatory Data Capture<br>Standardize data elements (e.g., Prod. Depts.)<br>Fill in existing data gaps<br>Implement DSS |
| | **'99:** | Improve Relative Value Units (RVUs) |
| **Cost Avoidance/Containment** | **'98:** | Consolidate HRMS, including Payroll $250,000<br>Reduce FECP/OWCP Costs ($1 million)<br>Consolidate Fee Basis Administration ($200,000) |
| | **'99-00:** | Consolidate HRMS, including Payroll ($550,000)<br>Reduce FECP/OWCP Costs $1 million<br>Consolidate Fee Basis Administration ($200,000)<br>Electric Dereg. Consol. Procure ($750,000)<br>Consolidate Benefit Travel Administration ($500,000) |

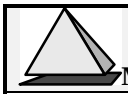
**Mission Goal:** Exceed by 10% the Proportion of Patients of Other Providers Who Achieve Maximal Functional Potential

| Operating Strategies | Performance Goals |
|---|---|
| **Improve CDI/PI/Palliative/ASI Scores** | **'98:** CDI - Meet VHA national average<br>ASI - Score 20 percent better than in FY97<br>**'99:** PI - Meet VHA national average<br>PAII- Meet VHA national average |
| **Improve Clinical Guidelines Scores** | **'98-00:** Improve Scores by 20 percent per year |
| **Increase Primary Care** | **'98:** Increase to 90 percent |
| **Expand Nurse-Managed Care** | **'98-00:** Increase by 10 percent per year |
| **Improve Organizational Performance** | **'98:** Implement Clinical Service Line - Prosthetics |

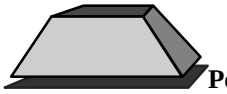
**Mission Goal:** 90% of Patients Define/Report Quality of VA Healthcare as Very Good or Excellent

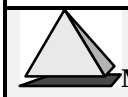
| Operating Strategies | Performance Goals |
|---|---|
| **Increase Inpatient Satisfaction** | **'98:** Equal VHA average score<br>**'99:** Score better than VHA average |
| **Increase Outpatient Satisfaction** | **'98:** Equal VHA average score<br>**'99:** Score better than VHA average |
| **Improve Access to Care** | **'98:** Activate 2 Community-Based Outpatient Clinics<br>**'99-00:** Activate 2 to 3 Community-Based Outpatient Clinics per year<br><br>**'98:** Expand Phone Care Program to 24 hours Network-wide<br><br>**'98:** Implement PACS and Tele-radiology<br>Install Computed Radiography<br>**'00:** Implement PACS and Tele-radiology<br>Full filmless interpretation and storage |
| **Decrease Acute Inpatient Use (Average Length of Stay)** | **'98:** Reduce average length of stay by 1 day<br>**'99:** Reduce average length of stay by 1 day<br>**'00:** Reduce average length of stay by 1 day |

| | |
|---|---|
| **Improve CDI/PI/Palliative/ASI Scores** | **'98:** CDI-Meet VHA national average<br>ASI-Score 20 percent better than FY97<br>**'99:** PI-Meet VHA national average<br>PAII-Meet VHA national average |
| **Improve Clinical Guidelines Scores** | **'99-00:** Improve scores by 20 percent per year |
| **Increase Primary Care** | **'98:** Increase to 90 percent |
| **Expand Nurse-Managed Care** | **'98-00:** Increase by 10 percent per year |
| **Achieve New Accreditation** | **'99:** Work toward CARF accreditation<br>**'00:** Achieve CARF accreditation |
| **Mission Goal:** Increase the Number of users of VHA by 20% | |
| **Operating Strategies** | **Performance Goals** |
| **VA/HUD Outreach** | **'98:** Request VA/HUD approval<br>Run Pilot Program<br>Selective Expansion |
| **Mission Goal:** 99% of Research Relates to VA Patient Care or Other VHA Missions | |
| **Operating Strategies** | **Performance Goals** |
| **Reduce Research Overhead Cost** | **'00:** Reduce Research Overhead Cost |
| **Mission Goal:** 95% of Trainees Rate VA Experience Equal to or Better Than Other Academic Training | |
| **Operating Strategies** | **Performance Goals** |
| **Implement Automated Education Tracking** | **'98:** Implement tracking at each facility<br>**'99:** Implement tracking Network-wide |
| | **'98:** Improve Electronic Communication<br>Fully Implement MS Exchange<br>Develop VISN intranet<br>Fully implement PC networking |
| **Implement VISN-Wide Electronic Record** | **'98:** Implement CPRS at VISN key site (WLA)<br>**'99:** Implement CPRS VISN-wide |

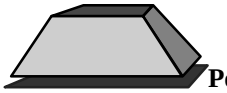


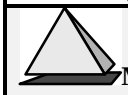
**Mission Goal:** Increase to 10% the Total Operating Budget Obtained from Non-Appropriated Sources

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Obtain Non-Appropriated Revenues** | **'98:** Improve DOD/TriCare revenues 15 percent over FY97<br>Increase MCCR collections by 20 percent over FY97 |

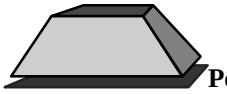


**Mission Goal:** 40 Hours per Year (2%) of an Employee's Paid Time Will be Committed to Continuing Education to Support/Promote Quality Improvement or Patient/Customer Service

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Enhance Employee Performance (Including Shared-Decision-Making with Patients)** | **'98:** Provide 16 hours of Customer Service and Performance Improvement Training<br>**'99:** Provide 24 hours of Customer Service and Performance Improvement Training<br>**'00:** Provide 32 hours of Customer Service and Performance Improvement Training |
| **Implement Automated Education Tracking** | **'98:** Implement tracking at each facility<br>**'99:** Implement tracking Network-wide |



**Mission Goal:** 100% of Employees are Able to Appropriately Describe How Their Work Helps Meet the Mission of the "New VA"

|  **Operating Strategies** |  **Performance Goals** |
|---|---|
| **Enhance Employee Performance (Including Shared-Decision-Making with Patients)** | **'98:** Provide 16 hours of Customer Service and Performance Improvement Training<br>**'99:** Provide 24 hours of Customer Service and Performance Improvement Training<br>**'98:** Provide 32 hours of Customer Service and Performance Improvement Training |

## 1997 SELECTED ACCOMPLISHMENTS

- Executive Leadership Council chartered five councils to provide assessments and recommendations, and serve as focal points for addressing key issues
- Established Management Assistance Council
- Formed Labor / Management Coalition
- Improved scores on patient and customer satisfaction survey
- Implemented 14 Clinical Practice Guidelines
- Improved scores on the national inpatient survey. Scores showed improvement in all but one category
- Shifted patient care from inpatient to outpatient area
- Reduced Bed Days of Care (BDOCs) by almost 28 percent
- Reduced total Operating Beds by 22 percent
- Established the Southern California System of Clinics (integrating VAMC Sepulveda, VAOPC Los Angeles, and the satellite outpatient clinics in Bakersfield and Santa Barbara)
- Reduced staffing while increasing number of patients receiving care
- Develop Service Lines in Clinical (Surgery in LA Basin) and Ancillary (Radiology in LA Basin) services
- Established Network Business Center
- Bulk purchase of physicians' Current Procedural Terminology (CPT) code books: Cost Savings, $27,000
- Bulk purchase of 167 PC Clinical Workstations. Cost Savings $200,000
- Consolidated purchase of four pharmacy automated prescription-dispensing machines. Cost Savings $355,000
- Developed Informatics Plan (FY97 investment of $11 million)
- Designed new telecommunications networks at all facilities, using state-of-the-art fiber optic vertical backbone and Category-5 cable to all workstation locations
- Procured electronics to support high-speed networking throughout VISN 22
- Upgraded telecommunications hubs to Asynchronous Transfer Mode (ATM) standard for 155 megabits per second backbone networking
- Implemented clinical workstations to replace terminals and provide immediate access to clinical information, through Computerized Patient Record System (CPRS), Internet and Intranet, and other computing tools
- Developed VISN standards for "charting locations" and negotiated best prices for leading technology under Procurement of Computer Hardware and Software (PCHS) contract
- Upgraded VISTA hardware at all VISN 22 sites to support clinical computing
- Installed Microsoft Exchange servers and activated "VHA22," the emerging personal computer (PC) network inter-linking all VISN computing resources (done under national Telecommunications Infrastructure Project (TIP))
- Developed Intranet plan
- Developed Education and Training Plan
- Developed Research Plan
- Increased Market Share. Preliminary end-of-fiscal-year data indicates VISN 22's total users (measured by Unique Social Security Numbers) increased by 4,000, about 2.5 percent, from 172,000 to 176,000
- Developed non-appropriated revenue streams by selling laboratory tests to DOD facilities (Marines at Camp Pendleton and 29 Palms, and Air Force at Vandenburg). TriCare Medical/Surgical contracts at VAMC Loma Linda. Eighty Prime patients enrolled, for total billing including prescriptions of $15,400

***Information as of December 12, 1997. The financial and workload information presented in this package is currently under review for use in budget justifications submitted to Congress.***

**BUDGETARY DATA SET (VISN 22)** **Table B-1**

| | 1997 Base | 1998 Tactical | 1999 Strategic | 2000 Strategic | 2001 Target | 2002 Target | 2003 Target |
|---|---|---|---|---|---|---|---|
| **1. Financial ($'s in thousands):** | | | | | | | |
| a. Medical Care, Sources of Funding: | | | | | | | |
| VERA Allocation for Medical Care | $918,475 | $933,710 | $933,710 | $933,710 | $933,710 | $933,710 | $933,710 |
| MCCR Collection [See Note] | $0 | $22,125 | $24,616 | $27,285 | $29,720 | $32,148 | $34,398 |
| Medicare Reimbursement | $0 | $0 | $0 | $5,000 | $10,000 | $15,000 | $20,000 |
| Tricare Collection | $10 | $250 | $500 | $1,000 | $2,500 | $5,000 | $15,000 |
| Other Sharing/Reimbursements | $3,500 | $10,000 | $15,000 | $20,000 | $25,000 | $30,000 | $30,000 |
| Planned Unobligated Balances | | ($5,000) | ($5,000) | ($7,500) | ($7,500) | ($10,000) | ($10,000) |
| **Total = Allocation + Revenues** | $921,985 | $961,085 | $968,826 | $979,495 | $993,430 | $1,005,858 | $1,023,108 |
| b. Percent Revenues to Allocation + Revenues | 0.38% | 3.37% | 4.14% | 5.44% | 6.77% | 8.17% | 9.72% |
| c. Distribution of Funding by selected activities: | | | | | | | |
| Acute Hospital Care | $261,477 | $265,400 | $269,381 | $273,422 | | | |
| Outpatient Care | $333,193 | $349,853 | $367,346 | $385,714 | | | |
| Long-Term Care | $93,699 | $96,042 | $98,443 | $100,904 | | | |
| Total | $688,369 | $711,295 | $735,170 | $760,040 | | | |
| **2. Federal Employment:** | | | | | | | |
| Average Employment (FTE), Total | 10,220 | 9,700 | 9,350 | 9,000 | | | |
| **3. Unique Patient Users (PRPs): [Unduplicated at the National Level]** | | | | | | | |
| a. Total Unique Patient Users (PRPs) | 168,177 | 173,222 | 179,285 | 186,456 | 193,915 | 201,865 | 205,983 |
| Percent Increase/Decrease from 1997 Base | | 3.00% | 6.60% | 10.87% | 15.30% | 20.03% | 22.48% |
| b. Distribution of PRPs by Eligibility Category: | | | | | | | |
| Category A | 141,101 | 145,333 | 150,420 | 156,436 | | | |
| Category C | 7,399 | 7,622 | 7,889 | 8,204 | | | |
| Non-Veteran Users | 19,677 | 20,267 | 20,976 | 21,816 | | | |
| Total | 168,177 | 173,222 | 179,285 | 186,456 | | | |
| c. Distribution of PRPs by VERA Patient Groups: | | | | | | | |
| Special Care Unique Patient Users | 7,400 | 7,500 | 7,750 | 8,000 | | | |
| Basic Care Unique Patient Users | 160,777 | 165,722 | 171,535 | 178,456 | | | |
| Total | 168,177 | 173,222 | 179,285 | 186,456 | | | |
| **4. Workload Episodes:** | | | | | | | |
| a. Outpatient Visits (Staff & Fee) | 1,903,776 | 1,868,160 | 1,859,410 | 1,865,686 | | | |
| b. Acute Hospital Care: | | | | | | | |
| Acute Hospital Beds | 712 | 660 | 605 | 550 | | | |
| Acute Hospital ADC | 454 | 450 | 445 | 440 | | | |
| Acute Inpatients Treated | 22,681 | 23,075 | 23,605 | 24,295 | | | |
| c. Long-Term Care: | | | | | | | |
| Long-Term Beds | 1,063 | 1,110 | 1,155 | 1,200 | | | |
| Long-Term ADC | 1,178 | 1,277 | 1,376 | 1,475 | | | |
| Long-Term Inpatients Treated | 4,637 | 4,960 | 5,380 | 5,600 | | | |
| **5. Number of Facilities:** | | | | | | | |
| VA Hospitals | 5 | 5 | 5 | 5 | | | |
| VA Nursing Home Care Units | 5 | 5 | 5 | 5 | | | |
| VA Domiciliaries | 1 | 1 | 1 | 1 | | | |
| Outpatient Clinics: | | | | | | | |
| Hospital Based, Independent & Mobile | 9 | 9 | 9 | 9 | | | |
| CBOCs, CBCs, Satellite & Outreach | 15 | 27 | 29 | 31 | | | |
| **6. Financial Measures (Medical Care):** | | | | | | | |
| a. Obligations Per Unique User Analysis (30% network goal): | | | | | | | |
| Obligations Per Unique User | $5,482 | $5,548 | $5,404 | $5,253 | $5,123 | $4,983 | $4,967 |
| Percent Change from 1997 Base | | 1.20% | -1.42% | -4.18% | -6.55% | -9.10% | -9.39% |
| Assumed Portion Current Services | | 3.75% | 7.63% | 11.63% | 15.45% | 19.92% | 24.28% |
| Percent Change Net of Current Services | | -2.55% | -9.05% | -15.81% | -22.00% | -29.02% | -33.67% |
| b. % Change in Unique Patient Users from 1997 base, from line 2a. above (20% network goal) | | 3.00% | 6.60% | 10.87% | 15.30% | 20.03% | 22.48% |
| c. % Revenues to Allocation + Revenues, from line 1b. above (10% network goal) | 0.38% | 3.37% | 4.14% | 5.44% | 6.77% | 8.17% | 9.72% |
| d. % of Acute Hosp.$s to Tot.of Acute $s + OP $s | 43.97% | 43.14% | 42.31% | 41.48% | | | |
| e. Outpatient Visits Per Unique User | 11.32 | 10.78 | 10.37 | 10.01 | | | |
| f. Med. Care Capital Obligations Per Unique User | $308 | $391 | $343 | $308 | | | |

# GLOSSARY OF ACRONYMS USED IN SUMMARIES

| | |
|---|---|
| A&MM: | Acquisition and Materiel Management |
| ADP: | Automated Data Processing |
| AFMA: | Automated Fabrication of Mobility Aids |
| ALOS: | Average Length of Stay |
| AMIE: | Automated Medical Information Exchange |
| ASI: | Addiction Severity Index |
| AY: | Academic Year |
| BDOC: | Bed Days of Care |
| C&P: | Compensation & Pension |
| CAIRO: | Computerized Information Repository |
| CARF: | Commission on Accreditation of Rehabilitation Facilities |
| CBOC: | Community Based Outpatient Clinic |
| CDR: | Cost Distribution Report |
| CIRN: | Clinical Information Resource Network |
| CMR: | Consolidated Memorandum Receipt |
| CMI: | Chronically Mentally Ill |
| CMOP: | Consolidated Mail-Out Pharmacy |
| COIN: | Computer Output Identification Number |
| CPG: | Clinical Practice Guideline |
| CPRS: | Computerized Patient Record System |
| CQI: | Continuous Quality Improvement |
| CSS: | Customer Satisfaction Survey |
| CT (CAT): | Computerized (Axial) Tomography |
| DHCP: | Decentralized Hospital Computer Program |
| DOD: | Department of Defense |
| DRG: | Diagnosis Related Groups |
| DSS: | Decision Support System |
| ELC: | Executive Leadership Council |
| EPRP: | External Peer Review Program |
| FIM: | Functional Independence Measures |
| FMS: | Financial Management System |
| FTE: | Full Time Employee |
| FY: | Fiscal Year |
| GAF: | Global Assessment of Functioning |
| GUI: | Graphical User Interfaces |
| HBPC: | Home Based Patient Care |
| HCFA: | Health Care Financing Administration |
| HSR&D: | Health Systems Research & Development |
| IPCC: | Intensive Psychiatric Community Care |
| IT: | Information Technology |
| JCAHO: | Joint Commission on Accreditation of Healthcare Organizations |
| KLF: | Kathy Lee Frisbee Menu |
| LAN: | Local Area Network |
| LOS: | Length of Stay |
| MAC: | Management Assistance Council |
| MCCF: | Medical Care Collections Fund |
| MCCR: | Medical Care Cost Recovery |
| MRI: | Magnetic Resonance Imaging |
| NIH: | National Institutes of Health |

| | |
|---|---|
| NHCU: | Nursing Home Care Unit |
| OPC: | Outpatient Clinic |
| OWCP: | Office of Workers Compensation Program |
| PTF: | Patient Treatment File |
| PI: | Prevention Index |
| PTSD: | Post Traumatic Stress Disorder |
| QI/QA: | Quality Improvement/Quality Assurance |
| QM: | Quality Management |
| SCI/D: | Spinal Cord Injury/Dysfunction |
| SEAT: | Service Evaluation & Action Team |
| SEP: | Special Emphasis Programs |
| SF-36: | Short Form with 36 questions yielding an 8-scale health profile |
| SOPC: | Satellite Outpatient Clinic |
| TBI: | Traumatic Brain Injury |
| TIP: | Telecommunication Infrastructure Project |
| UM: | Utilization Management |
| VARO: | VA Regional Office |
| VBA: | Veterans Benefit Administration |
| VISN: | Veterans Integrated Service Networks |
| VISTA: | Veterans Health Information Systems & Technology Architecture |
| VIST: | Visually Impaired Service Team |
| VSO: | Veterans Service Organization |

## VHA OFFICE OF POLICY, PLANNING, AND PERFORMANCE INFORMATION

Copies of this Network Plan Summary and other VHA Office of Policy, Planning and Performance information are available on the VA Intranet at:

http://vaww.va.gov/stratinit/index.htm
or
http://152.128.2.7/stratinit/index.htm

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